DOCTORAL RESEARCH IN

COUNSELLING PSYCHOLOGY

By

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The Experiences of Women Who Have Successfully Navigated Alcohol and Child Protection Services: Importance of Connection to Healing

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DECLARATION

This research or any part thereof has not previously been presented in any form to the University or any other body whether for the purpose of assessment, publication or any other purpose (unless otherwise stated). Except for any express acknowledgements, references and/or bibliographies cited in the work, I confirm that the intellectual content of this work is the result of my own efforts and of no other person.

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Table 1. Abbreviation

AA	Alcoholics Anonymous
ACEs	Adverse Childhood Experiences
BT	Beyond Trauma
CPP	Child Protection Plan
CSC	Children's Social Care
DH	Department of Health
DSM-V	Diagnostic and Statistical Manual
FDAC	Family Drug and Alcohol Court
HWR	Helping Women Recover
ICD-10	International Classification of Disease
LA	Local Authority
LAC	Looked After Child
LSCBs	Local Safeguarding Boards
MET	Motivational Enhancement Therapy
MI	Motivational Interviewing
M-PACT	Moving Children and Parents Together
NSPCC	National Society for the Prevention of Cruelty to Children
NTA	National Treatment Agency
OA	Overcoming Addictions
RCA	Relational Centred Analysis
RCT	Relational Cultural Theory
ROAC	Relationally Orientated Addictions Counselling
SADQ	Severity of Alcohol Dependence Scale
SMART	Self-Management and Recovery Training
TSF	Twelve Step Facilitation
WIT	Women's Integrated Treatment

Abstract

Background: A proliferation of research about maternal addiction problems and child protection involvement exists but there is a noticeable dearth of studies concerning how these services are experienced in conjunction. Research regarding the effectiveness of parental interventions for substance abuse is scarce in the UK. Further research highlights that social workers are inadequately prepared for working with parents with substance misuse problems even though substance abuse problems are as high as 70% in child protection caseloads.

Aim: The aim of this study is to elicit and understand the experiences of women who have successfully navigated alcohol and child protection services. How dual involvement with services was initiated, experienced, and identify sources of resiliency that enabled the women to live substance free lives.

Method: Semi-structured interviews were conducted with seven women to produce a qualitative research data. Transcripts were analysed using Interpretive Phenomenological Analysis (IPA) and a Relational Centred Analysis (RCA) to explore the lived phenomenological and relational experiences of these services.

Findings: Four main themes emerged across the narratives. Key findings include the importance of language used by services, which either continues to isolate or enhance the therapeutic alliance where hope, trust and connection to others flourishes.

Implications: The findings contribute to our understanding of women with addiction problems and their needs through the recovery process. These are discussed within a range of psychological theories and, finally, the implications for counselling psychology are considered.

Chapter 1 Introduction

I am aware that giving voice to the experiences of mothers who have had contact with child protection and addiction services should not minimise the impact that any action or inaction may have had upon their children in any way. However, the purpose of this study was to understand their experience of this dual process which involved both mothers and their children in order to make a contribution to the complex issues that surround mothers with addictions and the resultant need to protect their children.

The present study seeks to provide an understanding of the experiences of mothers who have had contact with addiction and child protection services due to alcohol problems. This chapter will cover the background to the study and position the research. This will be followed by a broad outline of child protection processes and terminology before reviewing existing literature and a rationale for embarking on this present study.

1.1 Background

The National Society for the Prevention of Cruelty to Children (NSPCC) observed there were 43,140 child protection proceedings in England alone during 2013 (NSPCC, 2014) and the number of carers with substance abuse problems as high as 70% in child protection caseloads (Hayden, 2004). No national study has been undertaken to gain the true number of substance abuse parents in social work caseloads and numbers that are available are dependent on local studies (Forrester

& Harwin, 2008). This highlights a significant problem of parents/carers who experience difficulties with substance abuse being brought to the attention of child protection services. Hayden's (2004) study reports that alcohol misuse was the major concern in comparison to illegal substances (74% and 61% of cases respectively), yet social workers felt ill-equipped to support parents with substance abuse problems.

This theme was repeated again in Galvani and Forrester's (2011) study that found newly qualified social workers in the United Kingdom (UK) were inadequately prepared for working with substance abuse parents, even though drug and alcohol users are the main group of service users identified by National Occupational Standards for social work in England (TOPPS, 2002).

The National Treatment Agency (NTA) is a specialist health authority with the purpose of governing illicit drug treatment services in England, and due to the frontline contact that social workers have with this client group, has made recommendations. These recommendations include making referrals to specialist alcohol and drug services and to carry out shared care work with child protection services (Department of Health (DH) & NTA, 2006; NTA, 2006). The high prevalence of alcohol and drug issues featuring in social work caseloads highlights a substantial problem, yet research in the UK has shown substance misuse specialists are rarely involved with parents when their children are referred to child protection services, even up to six months after allocation (Forrester & Harwin, 2006). The delay in referring parents to specialist drug and alcohol services would infer that the shared care and referral process recommended by the NTA are not the standard

experiences of parents involved with social services due either partly or wholly to their addiction.

Research shows families involved with child protection services are characterised by a depth and range of problems including domestic violence, substance misuse and mental health problems (Galvani, 2015). Each of these problems is worthy of specialist psychological intervention individually, but qualitative research has shown a lack of support and a lack of therapeutic help where mental health and domestic violence were concerned (Ghaffar, Manby & Race, 2012).

1.2 Theoretical position

As a Trainee Counselling Psychologist, my concerns are with the substance misuse field and how improvements to services can be informed from the perspective of those who experience these services themselves. I am drawn therapeutically to Relational/Cultural Theory (RCT) (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991) where empathy and connection form the basis of a healing therapeutic encounter. RCT will be discussed further in section 2.5.4. Through understanding the patterns of connection and disconnection, and the socio-cultural contexts in which they occur, then a greater understanding of the person's distress can be gained.

1.3 Alcohol dependence defined

Alcohol dependence exists on a continuum but nevertheless is categorised in the DSM-V (American Psychiatric Association, 2013) and the ICD-10 (World Health Organisation, 1993) as either present or absent. Therefore, in clinical practice alcohol dependence is subdivided into categories of mild, moderate and severe using the Severity of Alcohol Dependence Questionnaire (SADQ) (Stockwell, Murphy, & Hodgson, 1983). Harmful drinking and alcohol dependence are termed 'alcohol misuse', but due to the overlap of drug and alcohol misuse for some of the participants in this study, the term 'substance abuse' shall be used throughout this thesis for clarity when discussing people with addiction problems (see section 2.5.1).

Chapter 2 Review of the Literature

The purpose of this review is to provide an overview of child protection policy and proceedings and how these are experienced, particularly where there is parental substance abuse. This will be followed by a discussion of research findings relating to prevalence rates of child protection involvement. The backgrounds of mothers involved with child protection services will be discussed, particularly their mental health and social needs, as an isolated and marginalised group before finally reviewing the theory and practice of substance abuse treatment. Emphasis will be placed on the therapeutic relationship in the context of substance abuse treatment before considering RCT and resilience.

2.1 Legislation and child protection policy

2.1.1 Child Protection legislation

The Children Act (1989) guides professional practice when there are concerns for the safeguarding of children and the need to support families. The guiding principle of the Act is that the welfare of the child must be of paramount concern (Section 1). The Act also emphasises the principle of working in partnership with parents and this should form the basis of professional intervention in the lives of children and families (Allen, 2005).

The subsequent Children Act (2004) does not replace or amend much of the Children Act 1989, but following the death of eight-year old Victoria Climbié in 2000, Lord Laming conducted an inquiry on behalf of the Government to inform decisions

about whether new legislation and guidance were needed in England (Laming, 2003). The Laming (2003) report led to the Keeping Children Safe report (DfES, DH, & Home Office, 2003); Every Child Matters green paper (DfES, 2003) and resulting amendments to the Children Act 1989.

These reports found that although the Children Act 1989 was fundamentally sound, 108 recommendations for change were made. These included important changes to the national and local structures of children and family services, ensuring proper co-ordination, accountability and effective management (Long, 2014). Section 10 of the Children Act 2004 enshrines duty on children's service authorities in England to co-operate in bringing about improvement to the well-being of children.

2.1.2 Child protection process

Parton's (2007) analysis of developments in child welfare and protection shows that the recommended principle of working in partnership with parents set out in the Children Act (1989) is being encouraged in professional practice in England. Furthermore, the focus is not purely on child protection, and legislation sets out the role of the state as one of supporting families where there is a child or children in need (CIN), defined in the Children Act (1989) as unlikely to achieve or maintain a reasonable standard of health or development without the provision of services by a local authority. Although the ethic of partnership is embedded in practice, it is said there exists a 'blame culture' that emanates from within organisations and from the general public when a child death occurs (Ferguson, 2011). This has led to work

being top heavy where there are risks of ‘significant harm’ and those who do not pass this threshold struggle to gain support (Ferguson, 2011).

When a child protection referral is made, local authorities have a duty to investigate alleged concerns, gather information about the needs of a child and to assess if the parent/s is/are able to meet the care and safety needs of the child. Guidance from the Children Act (1989) defines a set of criteria that need to be considered for a ‘child in need’ or child at risk of ‘significant harm’ to be applied. The Children Act 1989 sets out under sections 19 and 47 specific duties and responsibilities of local authorities. While the local authorities have an overarching responsibility to protect and safeguard children in their local area, the protection of children is everyone’s business. The Children Act 2004 sets out under section 11 duties for other local agencies, police and health services to consider the safeguarding of children while carrying out their roles.

Local authorities must make arrangements to promote this co-operation with key partners and local agencies, to pool resources and bring about improvements to the child’s well-being. Another change introduced following the Laming report were those included in section 11, where a duty is placed on a number of agencies as mentioned above and encourages agencies to share early concerns about the safety and welfare of children before a crisis develops. Finally, local authorities were tasked with responsibility for setting-up Local Safeguarding Children Boards (LSCBs). LSCBs are responsible for safeguarding children and undertaking reviews following child deaths and serious case reviews (Long, 2014). In summary, the changes made to the Children Act 2004 improve outcomes by highlighting the need for improved

interagency working which takes into account the needs of the family by incorporating health and social care needs that may affect the family as a whole.

Parents' negative experiences of the family justice system are well documented and included feelings of isolation due to complex rules and language (Broadhurst, et al., 2017; Freedman & Hunt, 1998; Hunt, 2010; Lindley, 1994). The process of child removal itself has been described as a long and gruelling ordeal that is adversarial in nature (Cleaver & Freedman, 1995; Drumbill, 2006; Ghaffar et al., 2012; Ryburn, 1994; Smeeton & Boxall, 2011). Court proceedings are selective and deficit driven causing another source of trauma, shame and stigma for parents who are 'publicly branded as bad parents' (Mason & Selman, 1997; p. 24). Exceptions to these experiences are reported when a non-adversarial and problem–solving approach is taken promoting understanding and skill development that facilitates change (Harwin, et al., 2011).

2.2 Contexts of concern

Social service involvement where reasons for concern include parental/carer substance abuse, domestic abuse, and mental ill health have been documented (Galvani, 2015). Research shows that children being raised in an environment where a parent/carer (or both parents/carers) abuse(s) substances and/or where domestic abuse is present there are greater risks of significant harm (Cawson, 2002; Cleaver, Unell, & Aldgate, 1999; Ghaffar et al., 2012; Harbin & Murphy, 2000; Humphreys & Stanley, 2006; Kroll & Taylor, 2003; Velleman & Orford, 2001). Social work is a profession that offers a 'helping hand' when needed but most importantly aims to

protect those who are at risk of harm (Galvani, 2015). Social workers work with a range of diversity and complexity in different contexts including hospices, prisons, and hospitals and are not expected to be experts in all areas but to specialise in one (Galvani, 2015).

As mentioned in section 1.1, social workers can be working with up to 70% of their child protection caseloads containing issues of parental substance abuse. Due to the complexity of such cases and the 'toxic trio' of addiction, mental ill health and domestic abuse that have been found in serious case reviews (Galvani, 2015), a review of the theoretical and contextual issues concerning frontline social workers and the families they work with will be critiqued.

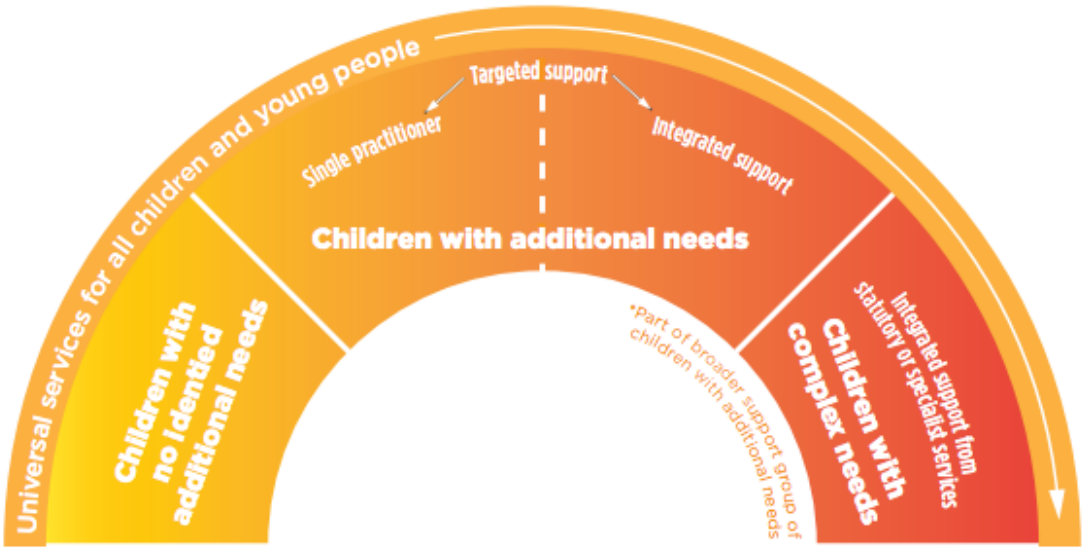
Historically, the link between poverty, child abuse, and neglect has been fraught with contention, resulting in little attention being paid to systematic research in the UK (Featherstone, 2017). The political message however, contradicts research with it being mooted that a link between poverty and increased risks of a child being harmed or neglected does not exist, and it is irresponsible for social work educators (and others) to suggest this link (Gove, 2013). Such rhetoric would leave one to assume financial burdens and lack of resources have no contributing effect to lives of troubled families. However, the geographical landscape shows children in disadvantaged areas such as Hull, Manchester, and Blackpool are six to eight times more likely to be on a child protection plan (CPP) or be an out-of-home looked after child (LAC) than children in more affluent areas such as Wokingham or Richmond Upon Thames (Department for Education, 2013a, 2013b).

Bywaters (2013) conducted a regression analysis on published data of child protection involvement and found statistically significant correlations at the local authority level between deprivation, LAC, and CPPs, with 50% variance in LAC rates being connected to deprivation scores. These findings show a link which must be considered, between poverty, deprivation, and child protection which adds to the complex backgrounds of substance abuse, domestic abuse, and poor mental health. The next section will provide context to the number of referrals and the sources of their initiation.

2.3 Referral Numbers and Sources

Information gathered from a Freedom of Information request was received from 75% of children's services departments in England, covering more than half a million children born in the financial year 2009-10, and shows that 22.5 per cent of children were referred to children's social care before their fifth birthday (Bilson & Martin, 2016). Although anyone concerned about a child's welfare can make a referral, some do not meet the statuary threshold for children's social care (CSC) and may be directed to universally available services or early help services. Families that do not meet the criteria of 'child in need' or at risk of 'significant harm' come under level two of Hardiker, Exton and Barker's (1996) hierarchical framework (see Figure1)**.** This framework is used in England and Northern Ireland to help classify and identify types of intervention available for differing levels of child need (Hardiker, Atkins, Exton, Perry, & Pinnok, 2002).

Figure 1. ***Hierarchical Framework Categorising Four Levels of Need***



Representation of the 'Windscreen Wiper' Model, by P. Hardiker, K. Exton, M. Baker, (1996). In Gillen, Landy, Devaney, and Canavan, (p.10, 2013).

The additional support is in anticipation of the prevention of neglect or to address emerging concerns in relation to health, social or educational needs. Engagement at this level tends to be on a voluntary basis either from one or multiple agencies. Families at this level tend to work in partnership with professionals to address areas of need. Local authorities have a duty to investigate concerns and gather information about the needs of a child when a child protection referral is made to assess if the parent is able to meet the care and safety needs of the child. Guidance comes from the Children Act (1989), which defines criteria that need to be considered for a 'child in need' section 17; or child at risk of 'significant harm' where a section 47 would be applied. The Children Act 1989 sets out specific duties and responsibilities of local authorities.

The general duty of the local authority under section 17 ‘child in need’ is the provision of services that safeguard and promote the welfare of children in their area and, as far as is consistently possible, promote the upbringing of children by their families when recognised as a child in need. This means that any services provided by the local authority can be provided not only to the child but also to the family if this will aid the safeguarding and welfare of the child (Children Act, 1989). The local authority (LA) has a duty to provide services to families that enable a child to be raised by their family. The LA can facilitate voluntary organisations or make arrangements with any other person they see fit to provide a service on their behalf.

Where a local authority has cause to suspect a child is either suffering or likely to suffer significant harm, under section 47 of the Children Act 1989, they will make or cause enquiries to be made. These enquiries are made in the consideration of whether action should be taken to promote the child’s welfare. Information is gathered from the local authority, housing authority, local health board, National Health Service or any other person authorised by the Secretary of State. Anyone working with children has a key role in their safeguarding; due to schools having high contact with children they have particular duties both in policy and legislation (Department for Education (DfE), 2011a, 2015b; Education Act, 2002).

As mentioned above, anyone concerned about the welfare of a child can make a referral. Forrester and Harwin (2006) reviewed referrals to social services for one hundred families with substance abuse problems and found they came primarily from non-professionals, such as neighbours or family 11.5%; or hospitals 17.5%, which tended to involve concern for young babies and parental drug misuse; only one

referral was made by a substance misuse professional. Findings of concern were the small number of referrals received from primary health care professionals for both substance abuse families and non-substance abuse families. These families totalled 290 and only seven (2%) were referred from health visitors and none from school nurses.

In Forrester and Harwin's (2006) study of one hundred families where substance abuse existed, the vast majority had no involvement with addiction services in 64 cases at six months post allocation and only one referral was made from substance abuse services to social services. These findings of low inter-agency working between social services and substance misuse are surprising considering previous reports of positive working relationships (Harwin & Forrester, 2002). The positive working relationships with substance misuse agencies expressed by social workers in (Forrester & Harwin, 2006; Harwin & Forrester, 2002), goes against the hypothesised difficulties relating to client interests and confidentiality issues (Local Government Forum, 1999).

2.4 Critical analysis of literature

The literature presented here will focus on mothers in particular; this is not meant to minimise the importance of fathers in the lives of children or their willingness to engage with services. Research by Harwin et al. (2011) has shown fathers involved with the Family Drug and Alcohol Court (FDAC) engaged more and stopped using substances in 36% of cases compared to none in the comparison group. The reasons for focusing on women here is due to the identification of maternal

substance abuse and that they are most frequently the sole carer (Forrester & Harwin, 2006), also they have automatic parental responsibility if unmarried (British Medical Association (BMA),2008).

2.4.1 Triad of difficulty

The wider contexts of difficulty identified in child protection cases include mental ill health and domestic abuse in families with substance abuse problems (Cawson, 2002; Cleaver et al., 1999; Ghaffar et al., 2012; Harbin & Murphy, 2000; Humphreys & Stanley, 2006; Kroll & Taylor, 2003; Statham, Candappa, Simon & Owen, 2002; Velleman & Orford, 2001). Research by Cox (2012) has highlighted the scale of repeat appearances of women in care proceedings, the scale of which and reasons behind the women's return to court were previously unknown. Cox refers this repetition of loss to the care system as a problem with no name as there is no agreed way of "referring to the social problem" (2012, p. 547).

The problem of repeat court attendance in England was highlighted by Broadhurst et al (2017) where 64,975 case files of women involved with repeat care proceedings between 2007/08 and 2015/16 were reviewed. These numbers include index appearance at court (53,784) and repeat appearance (11,191). Broadhurst et al's (2017) key findings show the reasons for index and repeat involvements reported by the local authority and the main concern was non-service engagement in 72% of index rates, followed by domestic abuse 65%, substance abuse 56%, and mental health issues in 51%. A narrower view of these findings for 354 women show rates of domestic abuse of 65% at index and 56.8% at repeat; index substance abuse at

55.9% and repeat at 49.7%, and mental health rates at index of 50.6% and repeat at 45.8% (Broadhurst, 2017). These findings show that the difficulties women present with during initial care proceedings are still present at repeat care proceedings, with service non-engagement rates reported by professionals as the highest mother related issue at 72.9% index and 65.5% repeat appearance (Broadhurst, et al., 2017).

These findings show current numbers for the 'toxic trio' reported elsewhere (Brandon, 2009; Cleaver et al., 1999; Galvani, 2015; Galvani & Cawson, 2002; Ghaffar et al., 2012; Harbin & Murphy, 2000; Humphreys & Stanley, 2006; Kroll & Taylor, 2003; Velleman & Orford, 2001). What Broadhurst et al's (2017) findings clearly show is these problems are still present at repeat care proceedings and professional opinion places service non-engagement as the highest mother related issue. This raises the question of non-engagement and why it remains so high even when the consequences are so great. Research has shown the predictive value of anxiety, social anxiety, and particularly depression between negative self-schema, self-esteem and persecutory ideas (Galbraith, Morgan, Jones, Ormerod, Galbraith, & Manktelow, 2014). Persecutory ideas include the belief harm will occur or is occurring which may be the case, not only in the lives of these mothers but also the very real fear they hold that their children will be removed (Alexander, 1996; Howell, Heiser, & Harrington, 1998; Klee, 1998; Nehls & Sallman, 2005), compounding their non-engagement.

2.4.2 Significance of mother's background

Broadhurst et al's (2017) study considered the childhood profiles of mothers appearing in repeat care proceedings by reviewing court case files using Felitti et al's (1998) adapted Adverse Childhood Experiences (ACEs) categories. The key findings show that mothers experienced much higher levels of adversity and harm during their childhoods than the general population, with 56% experiencing four or more different types of adversity. Rates of neglect, emotional, physical and sexual abuse ranged between 53% and 66% (Broadhurst et al., 2017). The NSPCC found prevalence rates of 24.1% for sexual abuse (contact or non-contact) in respondents aged 18-24 (Radford et al., 2011); whereas more than half the sample of mothers repeatedly presenting in care proceedings experienced childhood sexual abuse at 53.1%. Again, the findings in Broadhurst et al. (2017) and Radford et al. (2011) show 18.9% and 1.5% of this abuse was by a parent or caregiver and severity rates of abuse involving contact of 28.5% and 11.3% receptively for both studies.

This shows a significantly higher percentage of abuse being experienced by mothers who are repeatedly before the courts due to their own parenting difficulties but the prevalence of abuse in their own childhood homes is strikingly higher than experiences of abuse in the general population. The effects of sexual abuse in childhood are long lasting with associated psychological difficulties including PTSD, depression, suicidality, anxiety, substance abuse, interpersonal difficulties, and feelings of guilt and shame (Goodman, Koss, & Russo, 1993; Neumann, Houskamp, Pollock, & Briere, 1996; Polusny & Follette, 1995; Resick, 1993).

Felitti et al's. (1998) ACE categories, used to identity trauma in the backgrounds of mothers presenting to the family court in Broadhurst et al. (2017), were used to identify the relationship between adverse childhood experience and suicide risk in a retrospective cohort study of 17,337 adults by Dube, et al. (2001). This research found the ACE score had a strong graded relationship for suicide attempts in childhood/adolescence and adulthood ($p<.0001$), and that adverse childhood experiences, in any ACE category, increased the risk of suicide attempt between 2 and 5-fold. The relationship between self-reported alcoholism, illicit drug use, and depression was shown to reduce the strength of the relationship between the ACE score and suicide attempts, suggesting a possible self-medicating effect through substance use (Dube at al., 2001).

This trend in figures shows rates for all forms of abuse being much higher in the childhoods of the mothers in Broadhurst et al's (2017) case files, compared to the Radford et al. (2011) general prevalence study. This highlights for the first time a relationship between abusive childhood homes and adult appearances in child care proceedings; demonstrating the impacts of abuse, particularly in the childhood home, has implications for early development that persist into adulthood.

2.4.3 Parenting and attachment

The consequences of growing up in a home where a child's needs are not attended to are far reaching and have implications for forming adult attachments, being more susceptible to depression, and more likely to use destructive behaviour in conflictual situations (Styron & Janoff-Bulman, 2009).

Attachment theory is based on the early relationship interactions between child and caregiver forming a core attachment relationship, and which provide a child with a sense of security to form an internal working model (Bowlby, 1982). The internal working model can be likened to a relational schema (Baldwin, 1992) that becomes "cognitive structures representing regularities in patterns of interpersonal relatedness" (p. 461). These cognitive structures that form attachment relationships can be carried into adulthood and form the basis of interactions with friends and intimate relationships throughout the lifespan (Ainsworth, 1989).

There is considerable evidence to suggest that parental substance abuse impacts parents' capacity to form warm and emotional relationships with their children (Kandel, 1990; Schuler, Nair, & Black, 2002; Suchman & Luthar 2000). Further impacts of substance abuse on parenting include inconsistency, less sensitivity to children's needs, overall welfare, and being physically absent due to the seeking out of substances (Cleaver, et al., 1999; Howe, 2005; Kroll, 2004). American studies have shown adverse childhood experiences serve to continue rather than discontinue childhood trauma into adulthood (Felitti, et al., 1998; Taussig, 2002), and have implications for resiliency.

Resilience is defined as the ability to adapt well when faced with trauma or adversity (Alim et al., 2008; Collishaw et al., 2007; Feder, Nestler, & Charney, 2009). Resilience has been shown to protect individuals from psychiatric symptoms and therefore has implications across the lifespan. The protective factors of resilience against mental ill health were shown in a cross-sectional study where similar levels of childhood emotional neglect had been experienced but the higher resilient group

had fewer psychiatric symptoms compared to those with low resilience (Campbell-Sills, Cohan, & Stein, 2006). Another study followed individuals for thirty years and, despite experiencing serious childhood sexual or physical abuse, a significant number were resilient to the development of psychiatric symptoms at follow up due having at least one caring parent (Collishaw et al., 2007). Wingo et al. (2010) found resilience moderated the development of depressive symptoms in adults who had experienced childhood trauma and abuse.

The conditions in which resilience develops can be modulated by risk and protection factors. Risk and protective factors may come from environmental and personal variables that may either add to negative responses increasing risk or strengthen a person's ability to manage stress or conflict (Truffino, 2010). These factors may be evidenced at times of adversity to act as a compensatory measure to modulate effects which are positively developed in homes characterised by caring, nurturing, supportive role models in the absence of risk (Werner, 1995). Considering these findings and the childhoods of the women in Broadhurst et al's (2017) study, it can be argued that childhood abuse/neglect has serious implications in the lives of mothers who appear before the courts due to concerns about their own parenting abilities. Howe (2005) captures the thoughts of adult substance abusers as feeling alone, unlovable, a feeling they seek to escape through substances.

> *Many substance-abusing parents say they had loveless childhoods, believing that their parents had little time for them or actively rejected them ... the abuse of drugs or alcohol is seen as a way of trying to escape feeling alone and unloved and even unlovable. (p. 184)*

The effects of inadequate nurturing and trauma can be seen particularly in the lives of women facing removal of their own children. This will be discussed in more detail below considering stigma, loneliness, and support systems.

2.4.4 Impacts of stigma and isolation

'Stigma' is an Ancient Greek word that referred to a tattoo or a form of marking out the unruly slave or criminal (Lloyd, 2013). More modern understandings of stigma have been influenced by Goffman (1963) who describes stigma as arising through an attribute that separates or makes a person different:

> *"…and of a less desirable kind – in the extreme, a person who is quite thoroughly bad, or dangerous, or weak. He is thus reduced in our minds from a whole and unusual person to a tainted, discounted one" (p. 12).*

Goffman goes further to describe different types of stigma or blemish, those that are clearly seen as unavoidable are described as 'discredited' but those with inferred blemishes such as those arising from "mental disorder, imprisonment, addiction, alcoholism, homosexuality…" (p. 14) are termed 'discreditable'. The impact of being viewed as 'discreditable' has implications for a person's ability to be part of wider society. Two factors play a role in how stigma affects a person's acceptance into society, their perceived blame and perceived danger.

Jones et al. (1984) found that the greater the perceived danger of the 'discreditable' the more rejection they are likely to experience resulting from being seen as

unpredictable, disinhibited, and engaging in potentially bad or injurious behaviour (Room, 2001). A systematic literature review by Schomerus et al. (2011) compared characteristics of alcohol dependence stigma with stigma of other conditions across a number of countries and found alcohol dependent people are less frequently regarded as being mentally ill, are more likely to be held responsible for their condition, and to be socially rejected, concluding that alcoholism is a severely stigmatised mental disorder. As alcoholics are held more to blame for their condition they would embody the 'discreditable' form of stigma described by Goffman (1963).

In-depth interviews by Dale (2004) with 20 families who had previous involvement with child protection services; reveals how one mother found the experience of the case conference as reinforcing her sense of stigma and shame:

> *'An experience you'll never forget . . . very upsetting - it felt like everybody who was around that table was against you . . . everybody's looking at you, and then they are discussing you, your children, their recommendations - and you've not heard a word of what they've said before . . .' (p. 146)*

The stigma and social rejection experienced by mothers with alcohol dependence has wider impacts on the availability of social support systems and increased isolation or loneliness. According to the literature, people who have grown up in homes where unhealthy connections between parent or caregiver and child were experienced can be more prone to alcoholism than those who are able to form health connections in adulthood (Sachs, 2003).

Loneliness has been defined as a feeling of distress that arises through the perception of one's social needs not being met in the quantity or quality of their social relationships (Hawkley et al., 2008; Peplau & Perlman, 1982; Pinquart & Sorensen, 2001; Wheeler, Reis, & Nezlek, 1983). A literature review by (Cacioppo & Hawkley, 2009) found feelings of loneliness can impact cognition in various ways, affecting emotional and cognitive processes, resulting in susceptibility to an increased risk of depression symptoms (Cacioppo, Hughes, Waite, Hawkley, Thisted, 2006); and suicide (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

Lack of social support has been shown to impact feelings of loneliness which have been equated to sensations of physical pain, hunger and thirst which then serve to drive the person forward and seek social connection (Cacioppo, et al, 2006; Cacioppo & Hawkley, 2009). Loneliness can be further impacted by those with alcohol abuse problems as they may struggle to make or sustain friendships which increases their isolation (Alcoholics Anonymous World Service, 2001, 2005). Although, research shows that some women avoid seeking treatment for addictions due to fear of their children being taken in care, this results in treatment being received when their lives have become more chaotic (Alexander, 1996; Howell, et al., 1998; Klee, 1998; Nehls & Sallman, 2005).

The term dual-diagnosis was coined in response to the prevalence of co-occurring mental health and substance abuse disorders (Kessler, et al., 1994), and the need to integrate mental health and substance abuse services (Nehls & Sallman, 2005). The specific characteristics of dual-diagnosed women were identified as fearfulness, ambivalent emotions, anxiety and guilt, with backgrounds of abuse and violence

(Nehls & Sallman, 2005; Rosenbaum, 1979). Furthermore, the existential states such as anxiety, strong emotions, depression and loneliness are tempered through alcohol and drug use (Denzin, 1987; Diamond, 2006; Heyman, 2009; Milkman & Sunderwirth, 2010; West, 2006). The conditions of stigma, isolation and poor social supports act to compound the emotions of women who are fearful and lack either a secure base or adult protection (Schofield, 2002; Schofield & Beek, 2009). As women fear the loss of their children and continue to self-medicate an array of difficult emotions, it is not surprising they avoid service engagement as identified in Broadhurst et al. (2017).

Cleaver, Nicholson, Tarr, & Cleaver (2008) reviewed 357 social worker case files that had been referred due to child safety concerns and assessment had found either parental domestic abuse and/or substance abuse. The findings form these case reviews show Government Guidance highlighting the need for agencies to work together (Department of Health et al., 1999), are not always followed, particularly where domestic abuse and substance abuse co-exist. Cleaver et al. (2008) found "little evidence that social workers consulted with colleagues working in these specialist services to inform their decision making" (p. 7), and that domestic abuse and substance abuse services were not routinely involved at any stage of the process. Where collaboration of services did exist, this was only in 5% of domestic abuse, and 18.2% of substance abuse cases, although these problems were present in 72.7% and 60.3% of cases respectively.

Considering these findings, where the joining-up of services is not standard practice, it can be argued that the needs of these parents are vastly unaddressed once services are involved. The next section will critically review barriers to treatment.

2.4.5 Barriers to treatment

One barrier to accessing services is the fear and anxiety parents feel about losing their children during the early stages of child protection enquires, demonstrated through reluctance to admit difficulties with substance abuse, or mental health issues due to fear of a punitive response from social workers (Cleaver & Freeman, 1995). The outcomes for parents and children involved with child protection services due to substance abuse were shown in a two-year follow-up study, where 46% of children from one hundred families remained with their main carer (almost always the mother) Forrester and Harwin (2008). Considering less than half of children remain with their mothers, even when services have been involved, validates the real fear of parents involved with services and their reluctance to be honest about the difficulties they experience.

Findings on parental reunification for those children who encountered the FDAC system show a disappointingly similar picture. The final living arrangements for children who had been subject to the FDAC system found, 22 (39%) out of 56 (100%) were living at home (Harwin et al., 2011). However, as mentioned in section 2.4, an encouraging finding showed that fathers engaged in 36% of cases compared to 0% for the comparison group. Although the number of children returned to their primary caregiver in the FDAC study was surprisingly low (Harwin, et al., 2011), a

sense of fairness, and a process of self-understanding, vital to rehabilitation, was experienced by parents in the FDAC system (Harwin, Alrough, Ryan, & Tunnard, 2013). These findings show that irrelevant to the outcomes, parents found aspects of their interactions with the FDAC court gave a sense of fair treatment and self-learning experience, beneficial to their rehabilitation.

A systematic review by Greenfield et al. (2007) examined the characteristics associated with substance abuse treatment entry, retention, and post-treatment outcomes for women. Barriers to treatment entry identified included pregnancy, lack of services for pregnant women, fear of losing custody of child, and fear of prosecution (DeAngelis, 1993; Finkelstein, 1994; Grella, 1997). Other barriers identified relate to a history of trauma that includes sexual and physical assault (Copeland, 1997; Grella, 1997; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Najavits, Weiss, & Shaw, 1997), which were identified in all backgrounds of women in Broadhurst et al's (2017) study.

Although women may face greater social stigma and discrimination than men (Copeland, 1997; Finkelstein, 1994; Grella & Joshi, 1999; Tuten & Jones, 2003), and this may affect their treatment seeking, women may also be less educated than men about their treatment options (Wu & Ringwalt, 2004). Although these factors will affect women differently, having more than one of these characteristics will serve as a barrier to treatment entry (Greenfield, et al., 2007). The next section will review addiction treatment and mental health intervention.

2.5 Addiction and mental health intervention

In this section, an outline of NICE recommendations for alcohol abuse and treatment will be discussed before broadening out to addiction research and current research in this area. Emphasis will be given to the population group of this study, mothers with alcohol problems and dual-diagnosis, to consider any other presenting mental health problems. This will then be concluded with findings that show support is found to be lacking in assisting a process of change for this client group.

2.5.1 Recommended treatments for alcohol-use disorders

NICE guidelines (CG115, 2011) for alcohol-use disorders make recommendations for the assessment, diagnosis and management of harmful drinking. Harmful drinking in these guidelines is defined as *"…a pattern of alcohol consumption causing health problems directly related to alcohol"* (p.4). Further defining terms for alcohol dependence include psychological problems such as depression, preoccupation with alcohol, tolerance, craving, and a continuation of drinking in spite of significant consequences (NICE, 2011).

Mental health problems are comorbid with alcohol abuse, presentations include anxiety and depression, which may remit if abstinence is achieved or some people may need further treatment (NICE, 2011). NICE guidelines state that one million people in England are alcohol dependent yet approximately only 6% receive treatment. Two reasons for this are suggested as the period of time between

developing a problem and seeking help, and the lack of services in some parts of England as well as an under identification by professionals.

Therapeutic interventions such as alcohol focused cognitive behavioural therapy (CBT) are not always available or there are limits to these services even once the active use has been treated. Guidelines suggest interventions should be offered that promote abstinence and relapse prevention through intensive-community based intervention for those who are moderately or severely alcohol dependent (NICE, 2011). Recommendations outline that once alcohol consumption has ceased, if depression and/or anxiety continue after four weeks, then a referral should be made to treat these disorders in line with the relevant NICE treatment guidelines.

When working with those with alcohol abuse problems it is suggested that a trusting relationship is formed. Awareness of stigmatisation and discrimination that tends to accompany those with alcohol problems should be considered and the potential for this client group to minimise their problem. Treatment goals in section 1.2.2.1 of NICE guidelines state that abstinence is the appropriate goal for those with alcohol dependence and for those with alcohol abuse and comorbid psychiatric problems (2011). Interventions for alcohol abuse should adhere to evidence-based treatment manuals and information should be provided as to the benefit and availability of community support networks such as SMART Recovery or Alcoholics Anonymous (AA).

2.5.2 Cognitive Behavioural Therapy (CBT)

Psychosocial approaches to treat alcohol abuse seek to harness behaviour change that will bring improvement to patients' lives. One well known approach is cognitive behavioural therapy (CBT) used to prevent relapse and increase coping skills through a cognitive social learning model of addiction (Bandura, 1996; Marlatt & Gordon, 1985). The approach aims to teach cognitive, behavioural and self-regulatory skills when in high risk situations (Marlatt, 1985). The evidence for the efficacy of these approaches is low and will be discussed below.

A meta-analysis of 53 controlled trials was carried out by Magill & Ray (2009) into the treatment of adults diagnosed with alcohol or drug abuse problems using CBT to identify efficacy and client or treatment factors that predict better outcomes. A small but significant treatment effect was found using a meta-regression analysis but this continued to decrease at follow-up, being more effective in marijuana studies or more effective than no treatment.

In the same year, Litt, Kadden, Kabela-Corimer and Petry (2009) found network support (NS) increased abstinence rates by 20% at two years post treatment follow-up compared to network support and contingency management (NS+CM) or Case management (CM control condition). NS treatment resulted in greater social network support for abstinence and AA attendance than the other conditions, showing the latent growth modelling effects that an abstinence support network can have (Litt, et al., 2009).

A later meta-analysis by Riper et al. (2013) reviewed literature on the effectiveness of combining CBT and motivational interviewing (MI) to treat alcohol abuse and major depression. Twelve studies were reviewed and found that the combined CBT and MI has a small but significant effect on depression and alcohol abuse compared with treatment as usual (TAU). The small but significant effect of combined CBT and MI is promising, but focusing on behaviour change in the person neglects the wider contexts in which people live.

2.5.3 Community support networks

Two community support networks will be discussed as recommended in NICE (2011) guidelines for alcohol-use disorders, Self-Management and Recovery Training (SMART) and Alcoholics Anonymous (AA). Both approaches are community based and provided regular meetings although they hold very different philosophies. SMART is based largely on a cognitive behavioural approach emphasising an internal self-reliance whereas AA adheres to an external reliance on spiritual principles. Not surprisingly, a significant difference was found in the locus of control held between the two groups, with AA members exhibiting a greater external locus of control (Li, Feifer & Strohm, 2000). An argument exists that AA members are substituting one dependency for another that continues to render the person powerless (Ellis & Schoenfeld, 1990). There are several alternatives such as SMART for those who do not subscribe to an external or spiritual locus of control.

SMART is an initiative based in rational emotive behavioural therapy (REBT) (Solomon & Hagga, 1995; Walden, DiGiuseppe, & Dryden, 1980), and based on

CBT principles. The SMART approach to recovery from addiction holds that addiction is a learnt behaviour and therefore this 'choice-based' model is applicable to a learnt behaviour of addiction and people can learn to make alternative choices (SMART Recovery UK, 2012b). The model holds that the use of substances is ultimately an individual choice and once the physical effects have subsided continued abstinence is a mental struggle (SMART Recovery UK, 2013). The programme consists of four-points, building and maintaining motivation, coping with urges, managing thoughts, feelings and behaviours, and living a balanced life; which is delivered using specific tools and techniques (SMART Recovery, 2014). SMART consists of recovery meetings that are managed by a trained facilitator, also in recovery from alcohol abuse, and they demonstrate how to use the worksheets and group check-ins (Rooke, Jones, & Thomas, 2014).

This cognitive-behavioural approach teaches self-reliance using an adaptation of Albert Ellis' ABCDE mnemonic (Ellis & Volten, 1992), where people examine Activating events that cause emotion, irrational Beliefs, Consequences, Dispute the irrational beliefs, and thereby changing the emotional Effect.

An American study by Hester, Lenberg, Campbell, and Delaney (2013) evaluated the effectiveness of both SMART and Overcoming Addictions (OA), an abstinence-orientated cognitive behavioural web application, based on SMART but containing separate modules for other substances (Hester & Reid, 2013). The OA web programme also contains additional activities such as mindfulness exercises and motivational enhancement (Bowen et al., 2009); goal setting and change planning exercises (Miller, Zweben, DiClemente, & Rycharik, 1995). These conditions were

evaluated using data from 189 participants who were ascribed to either control group SMART, OA, or both in conjunction. The findings show that, for the 151 participants who completed base line and three months follow up interviews, all groups significantly increased their days of abstinence, reduced their number of drinks, and showed a decrease in alcohol related problems compared to baseline. No differences were found between groups, making both equally effective, however, greater improvement was found for all three dependent variables in the SMART only group showing an effect for face-to-face meetings (Hester et al., 2013), and reinforcing the need for face to face contact for this group.

Alcoholics Anonymous, another community support network, is recommended by NICE (2011). AA has more than 5 million members with groups in 181 countries (Humphreys 2004); and offers peer to peer support to help each other achieve sobriety and maintain abstinence (AA, 2001). The twelve-step programme of AA is intended to bring about internal psychological, emotional, and spiritual changes that improve wellbeing and surpass the immediate reward of alcohol consumption (AA 2001; Kelly, & Green, 2013b).

Despite the overt spiritual dimension of AA, rigorous reviews have found the behavioural mechanisms for change confer to multiple therapeutic factors provided by this approach that are mobilised simultaneously within a social network (Kelly, Humphreys, & Ferri, 2017; Kelly, Magill, & Stout, 2009). The effect of group self-disclosure has been likened to group psychotherapy theory (Yalom, 2008), where stigma, shame and guilt can diminish through a shared common suffering in an environment of acceptance (Kelly, et al., 2017).

Empirical reviews of AA and 12-step treatment have constantly found its benefits to be a least minimally helpful to the many as they begin their journey in attempting to recovery from alcohol abuse (Ferri, Amato, & Davoli, 2006; Kelly, 2003; Kelly & Yeterian, 2008; Kownacki & Shadish, 1999). AA is a community based fellowship where people work through the 12-step programme, and 12-step treatment (sometimes referred to as the Minnesota model; McElrath, 1997) tends to infer residential treatment where people receive various types of therapy but also receive an in-depth understanding of AA and may be expected to work through the 12-steps while in treatment.

The largest clinical trial examining 12-step treatment and AA practice for alcohol abuse (Project MATCH Research Group, 1993) found Twelve Step Facilitation (TSF) a professional, manualised intervention to facilitate AA engagement was at least as effective as CBT and Motivational Enhancement Therapy (MET) post treatment. Follow ups at 1 and 3 years showed a reduction in quantity and frequency for alcohol use (Project MATCH Research Group, 1997; 1998a; 1998b). Cooney, Babor, DiClemente and Del Boca (2003) found differences in TSF showing higher rates of continuous abstinence of 24% in the year following treatment compared to CBT 15% and MET 14%. This trend continued at year 3 with TSF 36%, CBT 24%, and MET 27% for continued abstinence (Cooney, et al., 2003). Substantial effects were found for those who were experiencing support for their drinking at intake, showing better outcomes at 3 years follow up in the TSF group, compared to those in other groups and was related to AA attendance (Longabaugh, Wirtz, Zweben, & Stout, 1998). Finally, individuals who attended AA, regardless of initial treatment approach, had significantly better drinking outcomes (Tonigan, Connors, & Miller, 2003).

2.5.4 Relationally orientated approaches

Relationally Orientated Addictions Counselling (ROAC) takes into account the manner in which counselling is delivered, the therapeutic alliance, and the environment in which it takes place (Reading, 2009).

Reading (2009) uses the term ROAC to denote therapeutic approaches that provide three important factors, attention to the significance of their experiences in the context of human relatedness; the quality of the therapeutic alliance, and seeing clients as autonomous. Autonomy in this respect, means listening to the client as a responsible adult, and helping remove the obstacles that hinder their autonomy, so they can make choices about their path to recovery from addiction (Reading, 2009).

Relational Cultural Theory (RCT) holds the central idea that healing occurs in connection, and isolation immobilises and prevents connection to others, particularly where negative expectations of others exist (Jordon, 2000). RCT considers the relational patterns of clients, their connections and disconnections, to rework these in the therapeutic relationship and bring about change (Jordon, 2000). Considering the 'toxic trio' experienced by women involved with child care proceedings (Broadhurst et al. 2017), the use of mutual empathy in RCT, serves to aid the change process by reworking a person's connections and disconnections in therapy (Jordan, 2000). Miller and Moyers (2015) reviewed four-decades of research, of the specific and general factors, that affect addiction treatment outcomes. Findings show, although little or no difference exists between approaches, what does show effect, are the relational factors displayed by therapists, such as empathy and therapeutic alliance.

They suggest that what is termed ‘common factors’ e.g. empathy, may not be so common and should not be “relegated to non-specific status” (p. 1).

In summary, the community support networks recommended by NICE (2011) guidelines tend to show no difference for outcome compared to other approaches. Although, differences found for SMART and AA tend to be found in the effects that regular face-to-face contact brings (Hester et al., 2013). This may be a result of the group effect where stigma, shame, and guilt found in those termed ‘bad parents’ (Mason & Selman, 1997), and/or alcoholic (Schomerus et al. 2011), can begin to move back in to growth and healing through empathy, connection, and the removal of isolation (Jordan et al. 1991).

2.5.5 Treatment needs of parents

The effects on children who have grown up in a home where domestic abuse and substance abuse exist leaves them at significant risk of harm (Cawson & Taylor, 2003; Cleaver et al., 1999; Harbin & Murphy, 2000; Velleman & Orford, 2001). This is due to difficulties addicted parents may have in organising their lives, and meeting the basic needs of the child (Cleaver et al., 2008). A systematic review of integrated treatment programmes for mothers with substance abuse problems found support for this approach compared to treatment as usual (TAU) (Niccols, Milligan, Sword, Thabane, Henderson, & Smith, 2012). Improved outcomes were associated with attachment based parenting interventions, child residing in treatment facility with mother, and improved maternal mental health, but opens questions on how to meet these needs (Niccols, et al., 2012).

Templeton (2014) evaluated 13 Moving Parents and Children Together (M-PACT) programmes, designed to meet the needs of families where substance abuse is a problem, in England, using a mixed-method approach. Results from this paper, report on the findings of a thematic analysis of interview data from 73 participants on the programme and thirty facilitators. The M-PACT programme draws upon child and family focused approaches, including, systemic theory, group theory, attachment theory, motivational interviewing, CBT, and person-centred philosophy (Templeton, 2014). The programme consists of 8 weekly meetings covering topics relating to addiction, communication, my family, and thoughts and beliefs. Findings from M-PACT show families benefitted from their children being involved in the programme, this encouraged spending time together, improved family communication, and meeting others with similar problems was also beneficial. Critique of the M-PACT programme focused on the shortness of the programme as the families were just settling in and this left less time for change (Templeton, 2014). This research is considered a step in the right direction in bringing families together but there is no discussion of substance abuse outcomes for the parents involved.

2.5.6 Summary

This review of the literature shows that social workers in the UK are managing caseloads where up to 70% of their clients are families where substance abuse is a cause for concern (Hayden, 2004). Further concern is that social workers feel unprepared to work with people with substance abuse problems (Galvani & Forrester, 2011; Hayden, 2004). Although the families involved with child protection services present with problems relating to mental health, addiction, and domestic

violence termed the ‘toxic trio’ (Galvani, 2015), there is significant delay in social workers referring parents to substance abuse treatment (Forrester & Harwin, 2006). Broadhurst et al. (2017) has shown the vulnerability of women presenting to the family courts in cases of child protection proceedings, and that the ‘toxic trio’ continues to exist for these women even when they appear before the courts again, showing their issues, usually based in childhood trauma, remain present.

Those with alcohol abuse problems have been identified as a heavily stigmatised group, being held responsible for their predicament (Schomerus et al., 2011), which is further compounded by the deficit driven approach of the courts where they are ‘publicly branded as bad parents’ (Mason & Selman, 1997, p. 24). Treatment approaches for substance abuse have shown small but significant effects for CBT (Magill & Ray, 2009), but the greatest long-term outcomes were found for those who used Twelve Step Facilitation (TSF) (Cooney, et al., 2003). These effects have been hypothesised as in part, being due to the group effect, where stigma, shame, and guilt can diminish through a shared common suffering in an environment of acceptance (Kelly, et al., 2017).

This review shows that women presenting before the courts have experienced, and continue to experience, difficult and traumatic lives, setting them aside, not only in their childhood homes and in their dealings with professionals, but also as a stigmatised and marginalised group in society. These marginalisation effects are tempered through understanding and acceptance in a group of similar others.

Chapter 3 Methodology

3.1 Research rationale and design

This study was conducted using a qualitative approach, employing semi-structured interviews, to gain an understanding of the experiences of mothers that have previously had contact with child protection services and alcohol addiction services. This study will adopt a resiliency framework to further understand adaptations that these women employed during times of adversity/trauma. Research regarding the effectiveness of parental interventions for substance abuse is scarce in the UK (Forrester, et al, 2008; Niccols, et al., 2012; Templeton, 2012). Niccols et al. (2012) call for further research to better understand the needs of mothers with substance abuse issues. The decision to interview mothers for this research was made due to the high number of mothers being affected by drink and drug use and this being a key factor in the number of children being subject to care proceedings discussed in section 2.4.1 (Cawson, 2002; Cleaver et al., 1999; Ghaffar et al., 2012; Harbin & Murphy, 2000; Humphreys & Stanley, 2006; Kroll & Taylor, 2003; Statham, et al., 2002; Velleman & Orford, 2001).

There are several reasons why a qualitative rather than a quantitative approach was chosen. This will be discussed followed a justification for employing a mix of Interpretive Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) and a Relational Centred Analysis (RCA) (Finlay & Evans, 2009) as the appropriate methodology.

3.1.1 Quantitative versus Qualitative Research

Quantitative and qualitative designs are the two main approaches of choice when developing a research study. This section will briefly discuss the major differences between these paradigms and the decision to discount a quantitative approach.

Stark differences exist between the two approaches and shall be discussed in terms of their epistemological, theoretical, and methodological underpinnings. Firstly, quantitative research is informed by an objectivist positivistic epistemology, seeking the development of universal laws of social behaviour that are supported statistically through measurement of an assumed static reality that is value-free (Yilmaz, 2013). On the other hand, qualitative research based on a constructivist epistemology, assumes a socially constructed reality where methods used are value-laden and flexible, seeking an in-depth description of the phenomenon from the perspective of the participant (Yilmaz, 2013).

The view of an objective reality endorsed by quantitative research means psychological and social phenomena are seen to be independent of those being researched putting distance between the researcher and participant. Broadly speaking, the quantitative approach is a type of empirical research used to test theories consisting of variables to determine if the theory predicts or explains the hypothesis (Creswell, 1994; Gay & Airasian, 2000). The theoretical positions differ as a qualitative perspective assumes that reality is socially and psychologically constructed and therefore the relationship between researcher and participant is closer and empathic (Bergman, 2008; Creswell, 2007; Denzin & Lincoln, 1998).

Methods used for quantitative research require standardised instruments or pre-determined categories for participants' responses using large representative samples that allow findings to be generalised (Yilmaz, 2013). Although generalisability is possible due to large sample sizes, there is a lack of insight into thoughts, feelings, and experiences as responses are pre-determined. Hence, the true meanings participants assign to the phenomenon being studied are lost (Patton, 2002) in a quantitative approach that concerns itself with deductive reasoning (Howard, Curtin, & Johnson, 1991).

Qualitative research, on the other hand, has been defined as an emergent, inductive, interpretive and naturalistic approach to the study of people, phenomena, social situations and processes through description of the meanings people attach to their experiences (Creswell, 2007; Denzin & Lincoln, 1998; Miles & Huberman, 1994; Patton, 2002). Brewer describes qualitative research as an approach that 'draws on philosophical ideas in phenomenology, symbolic interactionism, hermeneutics and other traditions to support the attention on "quality" rather than "quantity"' (2003, p. 239). This description points to the phenomenology, interactionism, and hermeneutics that form the core of the current research process to understand the life world of the participants involved.

3.1.2 Interpretive phenomenological and relational centred analyses

This section outlines the epistemological position of this study provided by the methodological framework of IPA and the adopted RCA. IPA is grounded in hermeneutic phenomenology, and was used to explore mothers' experiences and

meaning-making when reflecting on their previous contact with child protection services and alcohol addiction services. The detailed analysis that IPA provides, where participants can make sense of the processes they have experienced, is made possible by the assumed universal existence of self-reflection (Taylor, 1985). Phenomenological research seeks a rich textured description of these lived experiences. The idea that data emerge in and between researcher and participant underlines the relational centred phenomenological approach. Therefore, relational aspects that occurred between researcher and participant were seen to be an additional source of data in this project and the decision was made to incorporate this intersubjectivity and adopting an amalgamation of IPA and RCA methodologies.

3.1.3 Interpretive phenomenological analysis

In order to justify the appropriateness of IPA for this research, it is necessary to look at the aims and suitability of this qualitative methodology. The primary purpose of IPA is to provide researchers with a methodological framework that allows for illumination of the process of people making sense of their experiences on the assumption that people are ‘self-interpreting beings’ (Taylor, 1985). As such, human beings have a natural propensity to reflect on experiences, objects and people in their lives. The fundamental principles of IPA, those of phenomenology, hermeneutics and idiography, provide a means to examine these reflections of experience. The lived experiences of individuals are then examined and defined in their own terms as IPA looks at data provided by each individual prior to making any general claim (Smith, et al., 2009).

Due to the sensitive nature of this research topic and the phenomena being studied, IPA provided the means to focus on events and occurrences that become an experience when they are important to the individual (Smith & Shinebourne, 2012). IPA was deemed suitable for this research as Smith and Osborn (2008) suggest that IPA explores the individual's experience, to discover their meaning of the experience, and it is these individual meanings that are being sought in this research process. These individual meanings, using IPA, can then "offer a more detailed and nuanced analysis of the lived experience of a small number of participants with an emphasis on the convergence and divergence between participants" (Smith, et al. 2009, p. 202). Considering IPA's capacity to discover the personal sense and meaning-making of the individual by staying as close as possible to their words, language becomes the tool to discovering their meanings as stated by Marrow,

> *"using language as a tool, the researcher is able to plumb the depths of this experience to gleam meanings that are otherwise not observable and that cannot be gathered using survey or other data-gathering strategies" (2007, p. 221).*

This quote captures the importance of the spoken word in constructing the essence of a person's experiencing through their words particularly in the intersubjective space between research and participant.

3.1.4 Phenomenology

Phenomenology is an approach to the study of human experience and especially to the things that 'matter' to the person and make up their 'lived world' (Smith, et al., 2009, p.11). Phenomenological philosophy, initiated by Edmund Husserl (1859-1938) equips IPA with a range of ideas pertaining to the examination and comprehension of the lived experience that involves a stepping back from the everyday stance of being unreflectively immersed in the world, to adopting a phenomenological attitude (Shinebourne, 2011).

The phenomenological attitude, proposed by Husserl, involves a methodological process of phenomenological reductions. One reduction in this context means,

> *"…a 'leading back' (re-ducere) or redirection of thought away from its unreflective or unexamined immersion in experience of the world, to the way in which the world manifests itself to us" (Thompson & Zahavi, 2007, p.69).*

Another reduction is 'eidetic-reduction' which provides a way of getting to the essence underneath the subjective perceptions of each phenomenon. The techniques involved include 'free imaginative variation' (Husserl, 1970), and it is through the use of these reduction lenses that the different instances of the experiences under investigation are considered.

Consideration of the conscious experiences and the essential features of these experiences are termed ‘transcendental reduction’ by Husserl (Smith, et al., 2009). The attempt to deconstruct the conscious experiencing and understanding the essential features through description are the essence of Husserl’s influence of phenomenological psychology and IPA.

Husserl (1927) describes the phenomenological attitude as a shifting of our reflexive glance from one being engaged consciously on the thing, thought, value or goal, where the focus is not on the physical experience of how these things are known to us, to one where reflecting on these experiences and the ‘corresponding subjective experiences in which we become ‘conscious’ of them, in which (in the broadest sense) they ‘appear’ (Husserl, 1927, para. 2, quoted in Smith et al., 2009, pp. 12-13).

That which appear are termed ‘phenomena’ and the essential character of phenomena is existence through ‘consciousness of’ or ‘appearance of’ the things that are experienced. Here, Husserl is describing phenomena as a product, not only of the conscious experiencing of things or thoughts and the corresponding subjective experiences, but also the awareness of these experiences; this is what is termed phenomena.

3.1.5 Hermeneutic-phenomenology

Hermeneutics and the relation to phenomenology are described by Moran (2000) as:

> *"Phenomenology is seeking after a meaning which is perhaps hidden by the entity's mode of appearing. In that case the proper model for seeking meaning is the interpretation of a text and for this reason Heidegger links phenomenology with hermeneutics" (p. 229).*

Heidegger diverts from Husserl's transcendental approach to a stronger hermeneutic and existential emphasis. Heidegger's (1962/1927) *Being and Time*, defines the two Greek words that make up hermeneutic phenomenology, phenomena and logos. 'Phenomena' translates as 'show' or 'appear.' The appearance of something infers a new state, something that presents itself to the perceiver that can be contrasted to the previous state where it was unperceived (Smith, et al., 2009). The task of phenomenology, according to Heidegger, is in part the examination of the latent or disguised 'as it emerges into the light' but then to examine what appears on the surface to discover the deeper connections from which the thing appears to discover that 'which it is both part of and apart from' (Smith, et al., 2009, p. 24).

Logos can be translated to mean discourse, reason or judgement, and Heidegger accepted the meaning as 'to make manifest what one is "talking about" in one's discourse' (Heidegger, 1962/1927, p. 56). These two words in conjunction make clear that phenomenon is perceptual whilst logos is analytical and, together, can be used in the illuminating tasks of phenomenology.

The purpose being to examine ‘the thing itself’ as it shows itself to us is said to be a spontaneous happening and the logos aspect facilitates the making sense of that which appears. Through these methods of microanalysis and synthesis phenomenology becomes an act of hermeneutics.

Hermeneutics is a key theory of interpretation underpinning IPA. Schleiermacher (1998) wrote of hermeneutics describing a grammatical and psychological interpretation. Grammatical refers to the exact and objective meaning and psychological individuality of the speaker.

Fore-conception is the prior experience, assumption and preconceptions that are brought to the encounter by the listener, interviewer or analyst and may be an obstacle to interpretation (Smith, et al., 2009). Heidegger (1962/1927, in Smith et al., 2009) states:

> *“Our first, last and constant task in interpreting is never to allow our…fore-conceptions to be presented to us by fancies and popular conceptions, but rather to make the scientific theme secure by working out the fore-structures in terms of things themselves” (p. 195).*

This difficulty between the interpreter and interpreted, and the fore-structure and the new object, is agreed upon by Heidegger (1962/1927) and Gadamer (1990/1960). Agreement lies in the awareness of preconceptions as interpretation is underway. Preconceptions are ever present; being open to the text and what it is telling the

interpreter, while being aware of one's own biases as they arise, allows the text to present itself against the fore-meanings that are brought (Gadamer, 1990/1960).

3.1.6 Idiography

The third influence upon IPA is idiography, which provides a concern with the particular of each person. Smith (1999) asserts that,

> *"from an idiographic perspective, it is important to find levels of analysis which enable us to see patterns across case studies while still recognising the particularities of the individual lives from which those patterns emerge" (p. 424).*

Maintaining commitment to the particular is achieved on two levels. Firstly, the sense of detail that is found in the particular provides a depth of analysis. The second level is a commitment to understand how a phenomenon, an event, process or relationship is understood by a particular group of people in a specific context (Smith et al., 2009).

To this end, IPA differs from the nomothetic view of general laws that can be applied to large groups of people, to explain behaviour from large samples and remains committed to the particular. This is achieved through the use of a small group of participants and systematically analysing the data to gain an understanding of how the particular is experienced and the resulting general sense of the experience as phenomena (Smith, et al., 2009).

3.1.7 Relational centred analysis

The specific RCA adopted in this study emanated from the work of Finlay and Evans (2009). This approach is a general orientation to qualitative research and is compatible with phenomenological studies (Finlay, 2009b; Finlay & Molano-Fisher, 2008). The approach argues for the need to attend to the intersubjective relationship between research and participant as this provides access to understanding the "Other". Equally, it is in the being-with that both parties in the research encounter find potential for new meaning and growth (Finlay, 2010a).

A range of theoretical concepts and traditions underpin relational centred research, although at its core, existential phenomenological philosophy is used to bring out consciousness as embodied intersubjective intentionality, for example (Merleau-Ponty, 1945/1962). Relational centred analyses are particularly suitable for research involving the therapist or counsellor as it draws on relational and developmental aspects of psychoanalytic theory while maintaining the Gestalt and phenomenological interest in the here and now (Finlay & Evans, 2009).

This approach can be described as a hermeneutic variant of phenomenology leaning towards a relativist epistemology where reality is socially and psychologically co-created (Finlay, 2011). There is no pre-set structural method for relational centred research but there are specific principles guiding the researcher in the researcher-participant relationship (Finley & Evans, 2009). Finlay (2011) identified these principles to include, having an open and empathic presence, and being reflexive about what is happening in the intersubjective space of the research encounter. Data

gathered is then analysed either thematically, narratively, reflexively or through other creative methods but a phenomenological attention must be maintained (Finlay, 2011). The method of analysis employed in this research was narrative and thematic to allow the telling of the women's' experiences where themes and metaphors can be identified while reflexively evaluating the social context (Finlay, 2009b; Finlay & Madill, 2009). A diagram depicting the merging of the two approaches and further expansion can be found in Figure 2 of the data analysis section 3.6.2.

3.2 Epistemological and Ontological Standpoint

Here I will discuss my epistemological and ontological position in the first person and the standpoint I took throughout this research process. As epistemology and ontology are about the theory of knowledge and how it can be known it is important for me to set out and be clear about the aims and goals of this research and what it is possible to gain knowledge about.

3.2.1 Epistemology

The epistemological underpinnings that inform IPA are described by Smith et al. (2009) as 'an approach to qualitative, experiential and psychological research which has been informed by concepts and debates from three key areas of the philosophy of knowledge: phenomenology, hermeneutics, and idiography' (p.11). These three underpinnings and how they were deemed most suitable for the undertaking of this research project will be discussed.

Epistemology is the theory of knowledge of how reality is known (Morrow, 2007). Ponterotto (2005a) argued that counselling psychology research has tended to be dominated by quantitative research methods that are rooted in positivist and postpositivist epistemologies. Positivism attempts to verify existing theories, and assumes that measurement and observation of behaviour provide access to an objective reality. Postpositivism acknowledges the impossibility of accessing the objective reality; yet still assumes a closer accessing through falsification of existing theories (Creswell, 2009). Both of these paradigms are deductive, examining cause-effect relationships, whereas this research is inductive in nature, where I seek the emergence of experience with no predefined assumptions.

IPA does not assume the possibility of gaining direct access to the lived world of the other, but does assume the accounts given provide access to the thoughts and beliefs in connection to the phenomena as experienced by the other through engagement with the data to gain an insider perspective (Willig, 2009). The subjective experiences of each individual may show different experiences of similar situations as each person's experiencing is filtered through their own thoughts, beliefs and judgements they bring, attributing meaning to events (Willig, 2009). This provides the means I desired to elicit the subjective rather than objective data for this research.

3.2.1 Epistemological Position

The continuum of epistemological positions ranges from naive realism to radical relativism (Madill, Jordan & Shirley 2000). Taking a realist stance would mean

holding the belief that data provides knowledge of the world, how things really are and that one objective truth exists (Willig, 2009). As IPA and RCA hold an idiographic philosophical base and my awareness of possible differences in the experiences of the women in this research, I veered away from a realist paradigm with awareness that an idiographic analysis would be contained within IPA and RCA. The influence of symbolic interactionism in IPA means a concern for how meanings are constructed by the individual within both their social and personal world (Eatough & Smith, 2008; Smith et al., 2009), making this a more relativist stance. Taking a phenomenological attitude, as described by Husserl (1927), means taking a step back from the natural unreflective attitude to one of phenomenological reduction. Reduction in this case means leading back or redirection, away from the unreflective and unexamined experience of the world to how the object appears to consciousness using a phenomenological gaze (Husserl, 1927).

The phenomenological gaze here is second-order, where a shift is made from self-reflection or first–order to a focus on engagement with other people's experiences (Giorgi, 1997; Smith et al., 2009). Holding this view means that what appears to the individual in consciousness has a corresponding subjective meaning to become phenomena, it is these phenomena that I seek in this research and therefore justifies the chosen phenomenological attitude adopted. The epistemological standpoint of the phenomenological attitude resonated with me personally and academically as experience is not fixed but constructed through the process of interpretation (Willig, 2009).

I found the approach of IPA to be a guiding force for this research but lacked the capacity to allow my own experiences of being with the participant to be part of the analysis. Due to my own previous involvement with the research topic on a personal level this was something I began to struggle with when analysing using IPA alone. There was data emerging throughout the research process that held value to this study and the decision to add a relational dimension was made.

Through my readings of texts by Finlay (2011) and Finlay and Evans (2009) and reviewing literature on relational dimensions they were found to be compatible with an IPA methodology. Finlay and Evans' (2009) text proved invaluable to inform an approach that would allow my reflexivity to 'be owned'. The conscious and unconscious process throughout the research were brought into my awareness through dreams, waking moments, analysis, pre–and-post interview, and during supervision meetings where processing of the interview experience took place. During one of my supervisory meetings I became quite emotional by the fact that I had now heard the stories of seven women who had shared experiences similar to mine, yet during my own previous eleven years of abstinence I had not heard these experiences voiced.

Having shared the experiences of this research topic, I had to acknowledge that I came to this research with my own underlying assumptions. In order to reduce my preconceptions, I did not want to sit purely as researcher or as insider where my own experiences may colour my interpretations. A natural distancing took place where I dramatically reduced my own attendance at recovery meetings. The impact of reducing my own attendance at recovery meetings was one of trepidation but the effects of this change were bolstered through my own personal therapy as a

requirement of my training and evolving from a person needing on-going support to one of long term wellness. Use of supervisory meetings provided another space to reflect, process and bracket the effect some of the interviews had on me. These effects were most profound where there was a felt injustice in the levels of treatment offered. There was a striving for balance between being 'scientifically removed from' and 'open to' the data (Finlay, 2011, p. 23). Subjectivity can both "blinker and enable insight" so care was taken during analysis through a process of being questioningly reflexive and bracketing (Finlay, 2011, p. 23).

The values of relational research such as owning myself and accepting my own humanness, emotions, values, strengths and frailties while not denying my own social/cultural background that is brought to the encounter provided a comfortable place to sit throughout this process (Finlay & Evans, 2009). This being said, there was a balance to be struck between my own use of empathy for the experiences of the participants while recognising the differences as described by Reason (1988),

> *"I have that quality of attention so that I may be with you, alongside you, empathising with you; and yet not losing myself in confluence with you because the dialogue between us both bridges and preserves our differences (p. 219).*

3.2.2 Ontology

The questions of concern are to do with the experiences as lived, in relation not only to the self but also to others. Therefore, ontologically, it is not only the experiential dimension of the life-world and the sense-making that was sought, but also the

sociocultural and historical processes that shape how we understand and tell the stories of our lives (Eatough & Smith, 2008).

The aims of this study were to further understand the participants' life-world, not directly, as IPA acknowledges this is not possible, but as closely as possible through analysis to gain an insider perspective (Willig, 2009). The assumption of IPA is that the accounts people give of their private thoughts and feelings about an experience of interest produces knowledge of that phenomenon (Willig, 2009). Smith (1996, p. 263) argues that IPA is concerned with "what the particular respondent thinks or believes about the topic under discussion" making this analysis concerned with how a person thinks, feels and behaves in relation to the topic under discussion.

The relativist ontology of interpretive-constructionism holds that there are multiple realities, that each participant brings their own reality of the phenomenon, plus that of the researcher. The belief that meanings are co-constructed between researcher and participant makes this a transactional and subjectivist epistemology (Guba & Lincoln, 1994). This fits well with the relational-centred approach of Finlay & Evans (2009) that can be applied to the phenomenological project specifically. Here, the primary access to understanding the other comes through the intersubjective relationship where data collection takes place (Finlay, 2011). My position in this research is one of relativism, where multiple realities exist, but further reading drew me to a positioning of a critical-ideological paradigm.

Critical-ideological paradigms share similarities with interpretive-constructionism in that they both hold the view of multiple realities and they agree on a realist view that a 'real' reality exists in relation to power and oppression (Marrow, 2007). In terms of

this research, the individual experience of participants were sought in conjunction to the ‘real’ reality of the services they encountered making this research one of social justice. Thus, providing not only the individual reality pursued for its uniqueness to the individual’s situation and experiencing, but also what is the experience of external realities encountered through contact with social services and addiction services.

Difficulties were experienced in the reality of combining the two approaches discussed in sections 3.1.3 and 3.1.8, relating to the relational centred and hermeneutic-phenomenology. Balancing my analysis of the intersubjective relationship in the ‘here and now,’ attending to the reflexivity of the research encounter, and attempting to work through my preconceptions while identifying and interpreting phenomena, meant the analyses had to be separated and conducted separately.

The initial attempt to combine the approaches was too mentally taxing as the continued switching between being open, empathic and in real time of interview experience (Finlay, 2009b; Finlay & Madill, 2009), and analysis of phenomena as they appeared back then in the lived experience was difficult to maintain. This was overcome by completing the two analyses separately, firstly IPA was conducted, then going over the interviews again and re-listening with a deeper use of self and how the participant’s words resonated prompting different thoughts and feelings.

3.3 Reflexivity

In considering reflexivity and my position as researcher, it was important to think about my positioning and how this would influence not only the research but also the researcher. Epistemological reflexivity involves thinking about how I, as a researcher, bring my own personal assumptions and the impact they may have on the research process. Personal reflexivity was considered as to how this research process impacted upon the research process in terms of background, positioning, beliefs and values (Finlay, 2003a).

3.3.1 Epistemological and Personal Reflexivity

Taking a critical realist position, my aim was to capture the phenomena as experienced by the participants as closely as possible in relation to their experiences of the services encountered. During analysis, I struggled to refrain from interpreting while describing, having already decided that relational analysis would be the final stage, I now had to contend with description where I felt I was continuously repeating what the participant had said. Here I referred back to examples of analysis at the descriptive level to clarify my descriptive comments (Shinebourne, 2011; Smith, et al., 2009).

Linguistic and conceptual level comments were noted and changed at times as further analysis led me to reflect back and re-analyse previous sections as my overarching understanding changed. There was a moving between contextualisation

and de-contextualisation, needing to zoom in and out as close readings took on different meanings in relation to the whole.

The awareness of my own preconceptions that I brought to the research from my own lived experience was one of concern, as mentioned earlier. This was the first time I had heard women share their experiences and I had been concerned that this would cloud my interpretation. Throughout the process of the research I used my own experience as what has been termed a “biographical presence” (Smith, 2004, p. 45), where one’s own experiences are used to make sense of the data. Finlay (2011, p. 241) writes of reflexivity that “contributes to the understanding of the lived experience of others.” As a researcher and insider, I found the balance of these positions righted itself as the sharing of these experiences brought connection, grounding and the removal of aloneness, with the hope that this was experienced to some degree by the women who participated.

Motivation to pursue this research project was founded in a personal history of the ‘toxic trio,’ child protection and addiction services. Studying the literature, I found a lack of reporting of the longer-term outcomes where substance abuse exists in child protection cases and no discussion of abstinence rates (Forrester & Harwin, 2006; Templeton, 2014).

Personal reflections of my own journey, and the outcomes for children of parents who have received treatment and support from the FDAC, show a 39% reunification rate (Harwin et al., 2011). Addiction remission rates also showed a 48% Vs. 39% for the comparison group mothers ceasing their substance abuse compared to the

highly structured and supportive FDAC mothers (Harwin, et al 2011). Although this is a step in the right direction, I reflected on these improvements and considered them quite low based on the highly structured framework and input of the FDAC programme. Again, there was a nagging voice within me that wanted to be heard, feeling the literature was not truly representing the voices of those who had successfully walked the paths of child protection services due to addiction problems. As a woman who had personally walked these paths and benefitted from the process needed to achieve long term wellness which included the removal of shame, isolation, fear and not belonging to society, I found voices of women from their place of wellness was not represented in research and this was to form the basis of my research project.

3.5 Study Design

3.5.1 Recruitment

Recruitment methods used included contacting a number of social enterprises and residential rehabilitation centres across many counties and addiction services in the West Midlands. These services were identified by the researcher through Internet searches whom either telephoned or emailed them. Although some services showed interest and offered to help with recruitment, no participants were accessed through these sources for the following reasons. The researcher was told someone would get back to them, which did not happen, or they were unable to help due to not having service users meeting the criteria, or being due to drug addiction being more prevalent in the client group. The data for this current study came from two sources,

two participants were recruited through Alcoholics Anonymous and five participants were recruited through closed Facebook recovery groups.

In light of the difficulties in recruiting from social enterprises, residential rehabilitation centres and local addiction services, a suggestion during a research supervisory meeting was made regarding social media. This involved a minor amendment to the ethics application, which was granted (see Appendix A), and a total of five closed Facebook recovery groups were joined. The researcher searched for closed addiction and recovery groups and requested to join the groups. Following acceptance into the groups a behavioural agreement was read and agreed to as these groups have administrators that can exclude members who behave inappropriately or offend other members. The researcher added a post to the group page seeking participants to three groups (see Appendix B). There was a rapid response to the post, predominantly from a women-only recovery group. Interestingly, some members of mixed-gender groups only responded to the post on the women only group. The groups that were fruitful in recruitment included one for ex-residents of a residential rehabilitation facility; one was a mixed-gender group and one was a woman only group.

3.5.2 Inclusion and Exclusion Criteria

The research was aimed at mothers with previous involvement with both child protection and alcohol addiction services. Therefore, inclusion and exclusion criteria were given consideration. Firstly, involvement with child protection needed to have ceased for a minimum of twelve months. This criterion was set for a number of

reasons, seeking the experiences of child protection services while involvement was still current may have been too psychologically distressing for the women, so the research was aimed at those who have passed through these services, having resolved the reasons for involvement initially. This also reduced the risk of safeguarding issues arising.

Again, current involvement with alcohol addiction services would be cause for exclusion if this was not on a voluntary basis, being part of a care-order, or if active addiction was current. Involvement with services for reasons other than those pertaining to addiction would also be excluded.

3.5.3 Participant demographics

All participants have been given a pseudonym to protect their identities a brief overview of their length of abstinence, length of substance use, number of children, and removal and return of children is noted below.

Kim was 43 years old and had been substance free for two years at time of interview. Her substance use began when she was 14 years old. She has four children, two of which are grown adults now. These two older children were removed from her care for a temporary period of time prior to the births of her younger children. There were two separate involvements from social services.

Jane was 46 years old at time of interview and was two and half years abstinent. Her use lasted for 21 years and began when she was aged 19. Her four children reside permanently within her family.

Nicola was 33 years old at time of interview and was one year free of substances. Her use of alcohol had lasted 17 years since she was 15 years old. She is a mother to two children and they remained in her care.

Kayla was 32 years old at time of interview and has one year of clean time. Her time using substances began when she was eight years old and lasted approximately 24 years. Both of her children were adopted.

Jackie was 54 years old at time of interview and her use of alcohol began when she was around 37 years of age. This lasted for a total of four years and resulted in one of her four children being adopted. She was 13 years' substance free at time of interview.

Cara was 35 at time of interview and had been substance free for four years. Her problem had lasted for 16 years and began when she was 15. She has three children and they remain in her care.

Gillian was 54 at time of interview, was 13 years free of substance use and her problem had lasted for 26 years. She was age 25 when her problem began, is mother to five children, all of whom were taken into the care system for a period of time.

Table 2: ***Participant Demographics***

Participant Pseudonym	Age	Number of children	Remained with mother	Years of substance use	Years of substance cessation	Interview length in minutes
Kim	43	4	Yes & 2 temporary care	27	2	37
Jane	46	4	No – placed in family	25	2.5	49
Nicola	33	2	Yes	17	1	39
Kayla	32	2	No Adopted	24	1	35
Jackie	54	4	1 adopted 3 in care	4	13	84
Cara	35	3	Yes	16	4	79
Gillian	54	5	1 returned 4 in care	26	13	77

3.5.4 Sample size

This research consists of data obtained from seven mothers who previously experienced contact with child protection and alcohol addiction services and includes one initial pilot interview. The number of participants has been kept small and homogenous with suggestions of four to ten participants for professional doctorate research being adequate (Smith, et al. 2009).

3.6 Ethical Considerations

3.6.1 Ethical approval

Ethical consideration was made throughout this research and ethical approval for the study was granted by the University of Wolverhampton Ethics Committee in December 2015 (see Appendix A for ethical approval). The planning of this research was done in adherence to The British Psychological Society Code of Ethics and Conduct (2009) and The British Psychological Society Code of Human Research Ethics (2010).

3.6.2 Ethical procedures

All participants were given information sheets outlining the study during the face-to-face meetings, and had been briefed prior to meeting over the telephone (see Appendix E for information sheet). They were provided with the opportunity to withdraw at any stage of the research up to submission without consequence. The information sheet explained the research aims, confidentiality and limits to this, and

possible risks or benefits to taking part. Once agreement to continue was received, written consent was given by the participant (see Appendix D).

The five interviews from the closed Facebook recovery groups were arranged with dates, times and addresses provided by the women. These took place at various locations across England and Wales. Two were at the homes of the participants, one was in a garden of the participant's daughter's home, one was at a hotel where there was an Alcoholics Anonymous (AA) convention taking place, and one was at the head office of Alcoholics Anonymous. The two interviews from AA were arranged by the researcher as they were acquaintances known to the researcher through their own attendance at meetings. These took place at the home of one woman and the other at the researcher's home address.

In each case there was a brief getting to know each other through the shared experiences of the research topic but care was taken not to contaminate data as the researcher wanted the experience to be shared first-hand during the interview process. Participants read the information sheet and confidentiality agreement, and possible publication of the research were discussed. The confidentiality agreement was signed followed by the reminder that the interview could be stopped at any time, including the right to withdraw from the study. No ethical dilemmas emerged during or post interview, and participants were pleased with the opportunity to tell their experiences in the hope it would benefit others.

3.6.3 Confidentiality

Although confidentiality had been discussed and agreed, a further confidentiality statement was read out at the start of each interview to reiterate the need to share information with relevant services if concerns were raised for the well-being of either the participant or any children. This statement can be heard on all interview recordings and verbal consent being received. The researcher used clinical judgement, and no such concerns were raised during this research. Participants gave full consent to the interviews being recorded, by signing a consent form which detailed their rights (see Appendix D). Participants were clearly informed verbally and in the information sheet of the ethical procedures that would protect their identities, that only the researcher would listen to the interviews, and that these would be stored securely on a password protected memory stick.

In terms of debriefing, a period of time was spent with each participant following the interview to check their well-being and maintain the relational aspect of the process. Each woman (participant) was a member of AA and each had support systems within this organisation they could talk to. An information sheet containing a list of external resources was also provided (see Appendix F) should they feel the need to contact them as well as the University email address of the researcher and debriefing sheet (Appendix G). Participants were made aware of the anonymising of data collected such as changing names, locations, and names of addiction services within the transcripts to protect their identities.

3.7 Data Collection and Transcription

3.7.1 Interview design

Semi-structured interviews are a suitable method of collecting and analysing data using IPA (Smith & Osborn, 2008), as this allows for researcher and participant to explore in-depth areas of interest that arise during the interview process. There is freedom to modify questions based on the experience of the previous interview rather than the interview guide dictating the research encounter.

The research data was collected through in-depth semi-structured interviews and were recorded on a password protected recording device. All interviews were conducted face-to-face, giving the women a chance to tell their own experience, using their own language and words, as suggested in Smith, et al. (2009).

A semi-structured interview guide consisting of five questions was created by the researcher with guidance from supervisors and can be found in Appendix C. The interview schedule contains a preamble that introduces the research and makes clear that the voice and perspective of the mother was sought. Confidentiality and limits to this were reiterated and demographic details of age, length of problem with alcohol and length of time since this ceased were asked. The questions were designed to capture context of services and treatment involvement; access to services and support; and resilience throughout the process.

The purpose of the questions was to gain insight into the lived experiences of women and how child protection services became involved in their lives, what events

preceded this, and how contact was made. The schedule then explored experiences of and resources offered from addiction and child protection services, how this was experienced, and what was found to be beneficial or not to the women. The schedule ended by prompting participants to reflect back and identify any resources either internal or external that they drew upon during these difficult experiences. The reliance on the interviews being recorded meant that the researcher could dedicate attention to the process being co-constructed, rapport could be built and maintained, without missing vital data that note-taking would incur.

3.7.2 Transcription

Transcripts were transcribed verbatim and then analysed on an individual basis, completing one before moving to the next. Interviews were audio-recorded and transcribed by the researcher and ranged between 37 and 84 minutes with a mean average of 57 minutes. In total, there was approximately 6.7 hours of interview material, taking 40 hours to transcribe. Transcribing the interviews provided the opportunity to get close to the data which proved valuable to the analysis. Interviews were analysed using a mixture of procedures outlined by Smith et al, (2009), Shinebourne (2011), and Finlay and Madill (2009) which will be explained below.

3.8 Data analysis

3.8.1 Initial stages

The initial stage involved listening to the audio recordings, providing an initial opportunity for the researcher to be emerged in the data and write exploratory notes on the interview transcript. The next stage was to iteratively read the transcript and focus on descriptive, linguistic, and contextual comments, as described by Smith et al (1999). The next stage involved the exploration of the contextual comments and to begin forming emerging themes based on conceptual similarities. These emerging themes were noted in the left-hand column and given a descriptive label that would later become subordinated themes, capturing the essence that was conceptual yet remained grounded in the original data (Shinebourne, 2011).

3.8.2 Forming of themes

A word document for the data obtained from each participant was produced containing the emergent themes, text and line numbers. These were then printed out and the process of looking for themes began. Using the notes from the exploratory analysis to inform the emergent themes meant a higher level of abstraction had been completed and psychological concepts had been formed. These concepts were grouped across cases and the process of clustering together according to conceptual similarities began to form subordinate themes with descriptive labels.

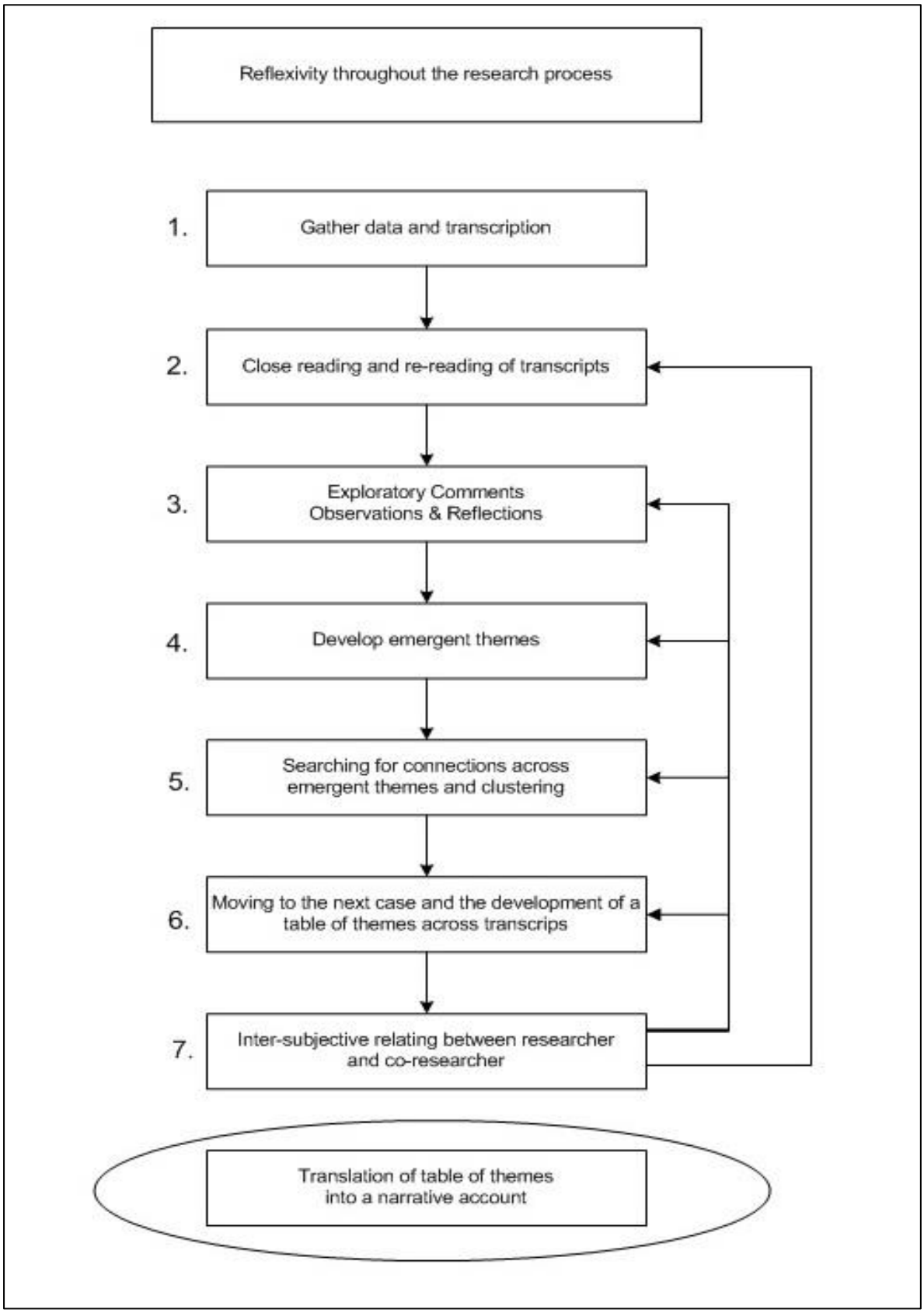
An attempt was made to capture the reflexivity and exploratory comments at the same time but this had to be abandoned. There was difficulty encountered during the

analysis process due to the switching of time frames. Immersing one's self in the past lived experience of IPA, and the present relational reflexivity of RCA, was simultaneously too taxing and the analyses were completed separately. Shineboune's (2011) chapter was found to be a very useful guide to what was becoming a rather complex process as a researcher attempting to bracket out the relational elements of the research encounter.

This was a time-consuming process, and there was an awareness of the need to go back to the original interview to re-listen with a phenomenological focus on the participants' embodied self-identity. This was to understand not only their lived experience at the time, but to construct the "creative adjustments they have developed in order to cope with past relational difficulties" (Finlay 2011, p.167), relating to their experience. As the data was being shaped the next stage was to cluster the subordinate themes into superordinate themes. For this process, tables of subordinate themes along with the verbatim text proved invaluable as they could be laid on the floor and the process of collapsing the subordinate themes into superordinate themes could begin.

This contained an aspect of eliminating some of the themes which was difficult, but to do justice to the participants and their data the subordinate themes that contained the richest data were retained. This iterative process involved returning to the data to check for meanings that were either polarised or similar (Shinebourne, 2011). The figure below shows the stages of analysis.

Figure 2 ***Analysis Structure***



3.8.3 Merging the analyses

Relational dimensions were added through reflexive awareness of the "embodied intersubjective space between researcher and participant" (Finlay, 2009, p. 167). The relational aspects that were noted, were then reviewed in terms of the transference/countertransference, focusing on the "here and now" moments that may have contained some of the "there and then" of the experience for both the researcher and participant (Finlay, 2009, p. 164). Having analysed the transcripts of participants' lived experiences, the researcher was able to reanalyse the relational dynamics of the research encounter reflexively (Finlay & Gough, 2003). This is facilitated through an acknowledgement of the relational dynamics without becoming preoccupied by one's own experience (Finlay, 2000a, 2000b), while drawing on Ashworth's (2003; 2006) fractions of the life world. This enabled some structured focus when seeking the emergence of the participants coping and relating, particularly during times of difficulty and current maintenance of their wellbeing. There was difficulty in combining the data, so the relational aspects that the participants brought were added within the idiographic analyses. This provided a clearer, and more individual understanding of each person's relational contributions, and the understandings they bring to the findings.

Final tables were made for each interview, highlighting quotes and line numbers for each of the final subordinate themes and superordinate themes (see Appendix I), and the corresponding relational dimensions (Appendix J). An example of an annotated transcript with initial comments, exploratory themes and emerging themes can be seen in Appendix K.

3.9 Evaluative Criteria

Findings in qualitative research may be seen as “merely subjective assentation supported by an unscientific method” (Ballinger, 2006, p. 235), unless the value of the research is justified. Quantitative research is valued on replicability using consistent and reliable measures, but replication in qualitative research does not stand up to these criteria as what emerges as ‘data’ is specific to the interpersonal and social context (Finlay, 2011). Evaluative criteria for qualitative research have been presented by Yardley (2000) consisting of four broad criteria and these shall be discussed in relation to this research.

Sensitivity to context: has been demonstrated through choice of methodology and analysis that would allow the idiographic and particular of each participant to be sensitively recognised. The idiographic and relational elements of the chosen approach have allowed appreciation and acknowledgement of, dynamics that occurred during interviews, allowing the context and relational dynamics to be documented within the idiographic analyses. The most important factor in this research was making women’s voices heard, particularly those who have resolved their problems. To this end, sensitivity to data has been painstakingly given, using verbatim extracts to support interpretations.

The literature review has demonstrated the researcher’s knowledge, and understanding of this subject area, and why the chosen methodology was used, to enable the voices of the women to be heard. The use of a reflexive journal has

proved an invaluable tool to the sensitivity, impact, and insight that the research encounters and analyses elicited.

Commitment and rigour: has been shown to this study, not only through the researcher's own experiences with the nature of this research, but also through working with a number of women professionally in an addiction service. Commitment and rigour are also shown through attentiveness to the participant during the interview and analysis process Yardley (2000; 2008). Both of these stages of the research have demonstrated a rigorous commitment on the part of the researcher in sourcing a homogenous group to complete this research.

Transparency and coherence: Yardley's (2000) third principle refers to the clarity of research process which has been provided in the procedure, recruitment methods, research inclusion criteria, and analysis sections which clearly describe the process involved in a coherent manner. Transparency can be seen throughout this research and a transparency trail can be seen in the appendices through the direct quotes of the participants. The researcher has included personal reflexivity, including personal background, and throughout this process has used a reflexive journal. The researcher has been open and honest during supervisory meetings and taken feedback on board. The researcher has endeavoured to be coherent in their methodology and personal reflexivity to reduce bias while remaining committed to this research. The merging of IPA and RCA was complex at times and it is hoped the reader will find clarity between methodology, research aims, analysis and findings.

Impact and importance: the real importance of the research lies in its ability to tell something that is important, interesting, or useful. This study was conducted to gain a greater insight to the experiences of mothers that have experienced both child protection and alcohol addiction services. There is a lack of research showing depth, explicitly of these experiences, particularly from the women themselves. It is hoped, this research, brings some useful insights particularly from those with long term abstinence, that may be informative to future practice for those working with this particular client group.

3.9.1 Summary

Based on the phenomenological, epistemology, and idiographic capacity of IPA, and RCA where individual styles of relating and experiences of participants can be captured (Willig, 2008), a broad semi-structured interview schedule was designed to capture the previous experiences of mothers that had navigated both child protection and alcohol addiction services.

Through analysis and clustering of themes, into subordinate and superordinate themes, it was possible to provide a representation of shared experiences of participants while still providing the opportunity to capture each unique experience of these services in the idiographic analyses (Hayes, 1997). This provided the place for the more nuanced and sometimes emotive dynamics that occurred during the interviews, where experiences past and present were seen.

3.9.2 Aims and objectives

The key aims of this research are to explore the experiences of women who previously had contact with both alcohol addiction and child protection services and maintained abstinence from alcohol. The objectives are to gain in-depth understanding of the personal lived experience from the perspectives of those who had previously navigated these services and were now living substance free lives. The overall aim of the research is to understand these processes retrospectively, and gain insight of what helps or hinders; and what sources of resiliency bring about lasting change for this client group. The aim of this research is to identify the therapeutic and healing aspects of these processes to inform statuary and psychological services.

Chapter 4 Findings

This chapter presents the findings which came from the data analysis for this research and will be presented in two parts. Firstly, an interpretive idiographic analysis will be presented to capture the individual experience of each participant, before moving on to a more in-depth analysis of generalised themes across cases. Superordinate themes and subordinate themes are presented below in Table 3.

Interpretive analyses of each transcript were conducted to provide an idiographic account and capture the particular complexity of each individual before moving to the next transcript. Hermeneutics is the theory of interpretation, and the accounts of each participant provided their attempts to make sense of their experiences. The researcher used a double hermeneutic in an attempt to make sense of their sense-making. The participant's sense making is first-order and the researcher's attempt to make sense of their sense making is second-order. The centre ground of interpretation was taken where attempts were made to draw out and disclose the meanings and experiences of the participants (Larkin, Watts, & Clifton, 2006; Smith, 2004).

These individual analyses were drawn from and remain grounded in the data through focus on the contextual, linguistic, and descriptive comments that formed the emergent themes and ultimately subordinate and superordinate themes. The idiographic analyses provided a short, concise, snapshot of the individual's unique experience before searching for the convergence and divergence contained within the more detailed subordinate and superordinate analysis.

4.1 Interpretive Idiographic Analysis

The identity of each participant has been protected and a pseudonym selected by the researcher has been given to each person.

Kim

Kim is a 43-year old mother of four with two years abstinence from drugs and alcohol at the time of interview. Kim's substance abuse had begun when she was aged 14 and had continued throughout her adult life. Kim experienced two separate involvements with social services, once when she had two children and again when she had four children. There was a temporary removal of her children during the first involvement and this separation from her children lasted for 18 months when they were placed in foster care and kinship care.

Kim identifies herself as someone who was unable to cope with life generally. She had experienced a life of prostitution, drug and alcohol abuse, interfamilial sexual abuse and violent relationships. The effects of her trauma had left her feeling isolated from society and she lacked support networks. Kim talks at length during the interview process about isolation, stigma and she said she thought *"I was mad, or there was something terribly wrong with me"* (p. 21) These thoughts had fuelled a lifelong search for help that was only relieved through her short period of abstinence when she found *"connection and hope"* though her attendance at Alcoholics Anonymous (AA) which was recommended by an acquaintance.

Kim engaged with the interview process honestly and appeared to retell her experiences at times as though she were back there in the situation. This was visible to the researcher as she shrank back in her chair, appearing small and vulnerable when disclosing her prostitution and help seeking. When she talked about her connecting to others, her voice became energised and self-assured. Rapport with Kim was easy to develop as she was previously known to the researcher, but there was a nervousness on both parts that was different from previous encounters with her, possibly because she was previously known to the researcher or maybe because this was the first research interview.

The researcher had purposefully separated herself from the participant for some months prior to the interview to bring some neutrality to the research setting. As a researcher, there was a sense of responsibility for wanting Kim's voice to be heard but remaining true to the content of the interview and her level of disclosure. This was managed tentatively and co-constructively during the interview and the nervousness seemed to emanate between what was previously known to the researcher and the level of disclosure during the interview. These moments were discussed post interview and highlights the lingering effects that stigma may hold on disclosure at a research level.

Overall, Kim is someone who still feels stigma in her life as a result of social service involvement, she felt let down by social services with recurring themes of not feeling understood and a lack of support once presenting concerns subsided. For Kim, a fundamental aspect of her experiences with social services was the needs of her children being seen in isolation, rendering her as unimportant and not seen as part of

a family unit. Indicates [added for ease of reading] - Kim stated *"[I] just felt pretty let down by them and they categorically said they weren't there for me they were just there for the children's sake"* (p. 17).

Although, separating the needs of parents from the needs of children was warned against in a Department of Health sponsored evaluation of child protection research concluded that *'The needs of parents and children cannot be compartmentalised'* (Bullock & Little,1995, p. 44). However, the separating of needs forms a significant part of Kim's story. Kim's initial plea for help concerned a self-identified need for "healing" from abusive relationships which affected her ability to function and cope. She felt let down by social services during the first involvement, who told her they were not there for her compounding her sense of isolation. Whereas, during the second involvement with social services, inter-agency working meant she began receiving group addiction support and her parenting role was maintained. Kim's words *"I'm still part of the human race, having that, you know, that mother- children input" (p. 18),* shows the powerful impact of connection that validated her as a human being and mother.

Jane

Jane is 46-years-old and was two and a half years abstinent at the time of interview. She is the mother of four children, three girls and a boy, all of whom reside permanently within her wider family. She is a professional and has worked as a nurse for many years. Her problem with alcohol began in her late teens and lasted for 21 years.

Jane has a supportive family and they intervened on numerous occasions to the extent that her three eldest children were subject to a residency order with her sister. Her family had attempted to prevent the involvement of services by taking on the responsibility of the children. The father of Jane's three daughters was said to be violent and this forms her narrative when asked about social services involvement. Jane describes a violent and controlling relationship that she sees as contributing to her problem drinking,

> "*I was in a bad relationship erm with the father of my daughters, erm he was violent and very controlling erm, this led me to drinking, and hiding the drink because he wouldn't allow me to drink, erm, and it literally got out of hand" (p. 2).*

During the interview process Jane was very open and honest about her experience with the various services she has been involved with. Her involvements were told in a series of events that unfolded and led to her eventual abstinence. She saw each part of her declining situation as leading her into the paths of people who were to guide eventual recovery; being arrested led to her living in a probation hostel and Jane saw this as a turning point,

> *"with the support of my support worker at the hostel… luckily for me he was on a 12-step programme in NA (narcotics anonymous) so he knew about addiction, so he gave me all the information of the meetings…I started going to church, I went to my first meeting…I was baptised* [in church], *erm and then I stated having contact with my family through my support worker"* (p. 9).

Jane felt unable to be honest about her true feelings to addiction services, she was "scared" they would liaise back to social services. Jane stated,

> *"I was scared to tell (addiction service) how I really felt in case they told social services but now I've got a phone full of people who I can ring and say the stupidest thing to (laugh)I'm having a bad day and they're like, ok I'll be there in half hour…*" (p.17).

Jane's fear of social services prevented her from being honest with her addiction worker but conversely it was her eventual honesty with members of AA that she accredits with her ability to change.

Jane also attends AA meetings and cites this as fundamental to her wellbeing today. Jane was quite vocal and loud throughout the interview very eager to tell her experiences. She never questioned the need for social services to be involved in her life but is still clearly angry with lack of support she received as her voice became louder saying,

> *"…where social services were concerned I was angry but they did the right thing, but I think social services could have done more…"* (p. 10).

Having clearly demonstrated the ability to change her life, her anger is related to what was experienced as threatening from social services and their lack of knowledge to refer her on to services. Jane reflected *"…rather than threatening the person because that don't help…"* (p. 10), and lists her discovered knowledge of

addiction treatment services that were not offered to her*, "… I know of all the 12-step programmes, the dry houses, the treatment centres, maybe if they are more aware of the treatment that is available…"* (p. 10). Jane's overall experience is framed in acceptance and understanding of the role of social services but anger at their lack of knowledge in referring her on to an abundance of services she has accessed through her own means.

Nicola

Nicola was interviewed at a convention for Alcoholics Anonymous held at a hotel and was just approaching her first year of abstinence at the time. Nicola was 33-years-old when interviewed, has a son and daughter, and both children had remained in her care during social service involvement. She described her difficulty with alcohol as starting when she was age fifteen until she stopped drinking a year ago. Nicola had responded to the researcher's post seeking participants on a closed Facebook recovery group page and the researcher arranged to meet her at the convention. There were concerns on the part of the researcher that AA may come to dominate the interview process, being at the convention, but this was not the case and her experience of AA tended to be expressed toward the end of the interview in relation to questions concerning resiliency.

Nicola is from the south of England and was able to bring her experience of services relatively recently as some of the participants' involvement dated back some years. Nicola was a mother at the age of sixteen and used alcohol as a *"solution"* to manage her anxieties and fears. By the age of twenty-one she began seeking help

from her GP as she was a single parent and feeling trapped, she had no-one to share her thoughts and feelings with. As the years passed her anxiety was intensified by her alcohol use and her GP referred her to an alcohol service where social service involvement was initiated.

Nicola spoke calmly and confidently until she was asked about addiction services and then she started to stutter as she recounted how she attempted suicide and stayed in a psychiatric ward. She believes that these actions resulted in her being hastily given a place on a full-time day programme at the addiction service. Nicola felt that social services did not understand addiction, and their attempt to support her to change was experienced as threats to take her children. She experienced a *"pressure"* that came from having social services in her life and an *"excitement"* when they left. This excitement would cause her to want to drink and celebrate as she had felt an intense *"stigma"* from social service involvement which signified her as *"a terrible mom."*

Nicola experienced the addiction services themselves as difficult - a mixture of people attending under the influence of substances was sending her confusing messages. She felt unable to connect to her key-worker as she seemed too busy to really listen which caused her to become defensive and less honest. Conversely, she identifies honesty as a key factor in her ability to change.

Kayla

Kayla was 32-years-old at time of interview and had been abstinent for one year. When the researcher entered the home, there were on number of cards on the table from her friends to mark her first year of sobriety. This was the most difficult interview for the researcher as both of Kayla's children had been adopted. The researcher experienced a great deal of counter-transference during this interview and in her dreams some days later. The dreams concerned the timings around Kayla's eventual sobriety and the permanence of adoption, what she was capable of achieving came too late and felt unjust.

Kayla presented as a calm, kind and compassionate person, not resembling the person she described during her interview. Kayla had been an angry young lady, whom herself had been adopted, as her birth mother had alcohol and drug problems. She appeared institutionalised, having been placed in a women's refuge when first pregnant at age eighteen, then a dry house, and multiple rehab centres until her children were eventually adopted. Kayla instigated the eventual adoption of her daughter by contacting social services due to her continued drinking and not wanting to give her daughter the same experiences she had had. Kayla had experienced sexual abuse at the hands of her brother for many years until she began to *"make the first hit"* and defend herself. This reaction of hitting out when feeling threatened instigated her initial involvement with social services and began her journey as a perceived unfit mother.

Throughout Kayla's journey of unsuccessful treatment attempts the theme of anger was constant. Her unprocessed issues had resulted in a self-philosophy of *"hurt before you get hurt"* and made sense in light of her abuse. She has found a place of peace in her mind today and the researcher felt humbled and honoured to hear her story but anger and frustration at someone that had not had their potential activated in time to continue being a mother to her children. Kayla found her own way eventually through her attendance at AA where she has faced what she thought impossible. Kayla has changed her perception of the world from an uncaring and unsafe place and through help with her AA guide she modelled herself on what she saw, people who demonstrated compassion, understanding and kindness, the thing that had been given to her, she now began to apply to herself. Laughter was shared and it felt good.

Jackie

Jackie was 54 at time of interview and has four children. Her youngest child never returned to her care and was adopted by long-term foster carers. Her drinking became a problem in later life when she was 37-years-old but she recognises, looking back, that it had always been an issue. At the time of interview, she has not been drinking alcohol for 13 years.

The interview took place at the Head Office for AA where Jackie had arranged for a room to be used, and the researcher was given a guided tour of the building and a thorough history of AA. This unnerved the researcher slightly feeling this context may begin to dominate the research interview but this was not the case. Once the

interview was in process it took Jackie sixteen minutes to answer the first question of how social services became involved in her life. Again, the researcher was uneasy at what seemed to be an avoidance of the question. A lengthy family history was provided, including details of a violent marriage before she disclosed it was her violence toward her son that resulted in the removal of her children. On reflection, the researcher began to understand why Jackie had needed to provide such background information before disclosing her own aggression, and that other participants had also set a scene embedded in childhood and relationships before answering the question of social service involvement showing complex life circumstances that lead to involvement.

All of Jackie's children were cared for out of home for a number of years, those who returned did so when aged eighteen (although not addressed with her directly this may have been due to their age and not through social service agreement). Jackie talks at length about her ex-husband; he seems to still occupy her mind and even though she has been remarried for many years the effects of the marriage are still present. Jackie maintained a mentality of 'fight' and was fighting a battle with social services. The violent marriage and resultant aggressive interacting with her children seemed to find a new outlet aimed toward services but she credits this attitude with her ability to *"survive the system"* (line 885) that she experienced as oppressive. Jackie's eventual abstinence was the result of her attendance at AA where she began to change her *"rebellious…patterns"* (line 886).

The researcher's initial irritations while relating with Jackie were seen in a new light as the interview progressed and through analysis. Jackie had actually reconditioned

herself through a programme of recovery and allowed her harsh defensive patterns of behaving to be moulded, softened and shaped until she became her true self.

Cara

Cara was 35 when interviewed and had not drank alcohol for four years. She states she had a drinking problem since age fifteen. She has three young children whom were not taken into care but were placed away from her in kinship care and contact was supervised by them for a period of time.

Rapport between Cara and researcher was instant; she was open, warm and kind. Cara had attended the same residential treatment centre as the researcher, so some implicit understandings existed, of the particular processes involved in that treatment setting. She described herself as *"manipulative"* when younger, having a public persona of perfection in her education setting and a private drinking persona that expressed self-destruction and an *"obliterating"* self.

The researcher felt sadness connected to the word *"obliterate"* (line 34) as Cara states she came from a good home and did well at school before progressing to University but some part of her was seeking destruction. Cara began building a family, highlighting that she lived in an *"isolated place"* (line 109) and begins presenting at the doctor's complaining of anxiety but her drinking was also increasing at this time. Eventually, she takes an overdose and this alerts social services. Her family monitor her contact with her children but she seems confused by the lack of concern or support offered to her. She questions being allowed to take her child from

school when drunk and there is a sense of her predicament not being recognised. Cara feels confused by social service involvement as there is a lack of urgency and her family are left with the role of supervising her suitability to see her children. She feels *"looked down upon"* by the social worker again highlighting the stigma associated with addiction, women and motherhood.

Cara has a residential detox but is returned home and resumes her drinking. She over compensates, using her perfectionist tendencies for her emotional unavailability to her children, but this creates greater shock in her small community as her world comes tumbling down. Cara whispers as she repeats her concern over what the neighbours must have thought as now her battle with alcohol had become public. Cara eventually enters a treatment centre following a second detox. She begins a long process of change, challenging all of her self-seeking behaviours until she is left with herself. She reconnects psychologically and sees how her behaviour has impacted on others. Her wall of pent-up emotion is released and she begins to connect with her peers in treatment through their shared experiences. Cara became fully open and honest during her treatment, placing her trust in others, and finding meaning in her experiences.

Gillian

Gillian was fifty-four when interviewed, had not used drugs or alcohol for thirteen years, and is the mother to five adult children. The interview took place in the garden of her youngest daughter's home whom Gillian was visiting and they appeared to have a close relationship.

Gillian had grown up in a home where her parents were not physically present due to their work commitments. She finds similarity in her own emotional unavailability to her children as she was psychologically unavailable to her children. She draws these similarities when reflecting on her own sexual abuse at the hands of her brother and that experienced by two of her daughters. She was unprotected from her brother due to absent parents and she failed to protect her daughters as she was physically present but emotionally unavailable.

Gillian's lifestyle when using substances caused harm to her children, there was a history of sexual abuse from a neighbour and drug dealing from the home which brought violence, and the eventual removal of her children. Gillian was open and honest about not only her experiences but also the impact to her children. Her own experiences of abuse had not been disclosed and she remained silent. She had no support other than her father, and remained deeply untrusting, which impacted on her eventual treatment in a residential rehabilitation centre and her relationships with social workers.

Gillian had felt suicidal and alone since childhood but finds purpose and meaning in her children. Knowledge of her daughters' abuse drove her forward as she felt compelled to let them know *"it wasn't their fault."* Gillian began to grow during her time in treatment being pushed out of her comfort zone to attend college. The researcher's overall sense of Gillian was that she had been silenced since childhood, feeling trapped and alone in her abuse. This was reinforced in adult relationships where violence was used against her for speaking out. There is a stark contrast

between the quiet and shy person she describes to the person she is today who has a lot to say and new-found confidence.

4.2 Subordinate and Superordinate Themes

This section presents the findings of an Interpretive Phenomenological Analysis (IPA) that was synthesised with the relational analysis outlined by Finlay and Evans (2009) by exploring the embodied self-identities and coping strategies developed. Using intersubjective theory described by Stolorow and Atwood (1992) allowed inclusion and acknowledgment of interactional dynamics within the interview to capture the manifestation of past and present experiencing where relevant.

This research generated a large quantity of data and required a great deal of time to organise the emerging themes and capture the participants' sense making. There was overlap and much deliberation as to which themes best fit together, particularly in terms of timing along the trajectory of experience, relationships with others, and the overall experience of addiction service and social service involvement. To overcome this, multiple rearrangements of emerging themes into subordinate and superordinate themes took place to capture the essences of experience.

Direct quotes from the interviews are used throughout the findings section to enrich and bring depth to the themes and ensuring participants' voices are heard. The quotes are presented in italics and followed by pseudonym and line number/s for cross reference with original transcript. The quotes are taken verbatim from the interview although on occasion a word is added for readability. The transcription

conventions used are shown in Appendix H, depicting the key used for non-verbal cues, omitted, changed or added text. Through the process of analysis four superordinate themes emerged from the data pertaining to the research question, what are the experiences of women who have successfully navigated alcohol and child protection services? An overview of the themes and frequency can be seen below (Table 3).

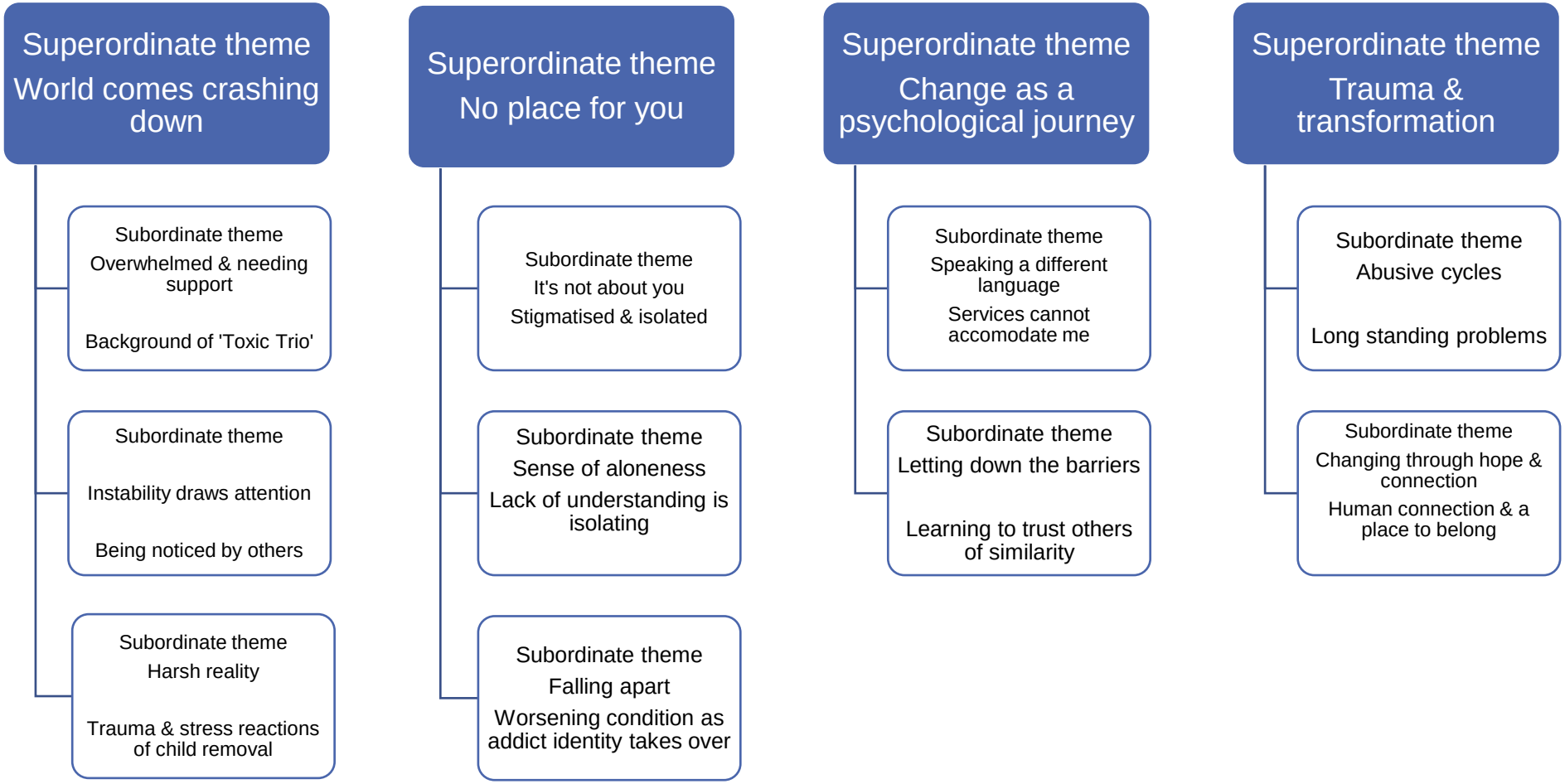
Table 3 ***Overview of Superordinate and Subordinate Themes for each participant***

Key: Theme present = ✓ Theme not present = ✗

Superordinate theme	Subordinate theme	Kim	Nicola	Jane	Kayla	Jackie	Cara	Gilliar
World comes crashing down	Overwhelmed & needing support	✓	✓	✓	✓	✓	✓	✓
	Instability draws attention	✓	✓	✓	✗	✓	✓	✓
	Harsh reality	✓	✓	✓	✓	✗	✓	✓
No place for you	It's not about you	✓	✗	✓	✓	✗	✓	✓
	Sense of aloneness	✓	✓	✓	✓	✓	✗	✓
	Falling apart	✓	✗	✓	✓	✓	✓	✓
Change as a psychological journey	Speaking a different language	✓	✓	✓	✓	✓	✓	✗
	Letting down the barriers	✓	✓	✓	✓	✗	✓	✓
Trauma & transformation	Abusive cycles	✓	✓	✓	✓	✓	✓	✓
	Change through hope & connection	✓	✓	✓	✓	✓	✓	✓

The presented findings are those found by the researcher and the influence this has on the analytic process and theme identification is acknowledged. In the following pages, the researcher will present a narrative of each theme that emerged, providing a coherent account of the experiences shared by the participants of their involvements with both social services and addiction services. Themes will be explored in relation to psychological theory and research in the discussion section. An overview of superordinate and subordinate themes is presented in Table 4 to provide a clear picture of how themes link together.

Table 4 Overview Depicting Relationship within and Between Themes



4.3 World comes crashing down

This theme captures elements of the participants' lifeworld in the periods before, during and shortly after involvement begins with social services. All of the women experienced difficulty coping within relationships that were either abusive, unsupportive, or a lack of support systems in general. Chaotic lives become exposed as addiction, aggression, and an inability to cope either draws attention to the women or they actively seek help. All of the women experience involvement with social services to varying degrees and describe the impact this had on them. Some of the women felt threatened, unsupported or abandoned, further impacting their mental health and need to numb feelings through alcohol and drugs.

Terms used by the women to describe their worlds falling apart include Kim's need for *"support,"* (line 57), and *"healing"* (line 58) and her inability to *"cope with the children"* (line 45). Nicola felt an urge to *"escape"* her young child through alcohol but felt *"threatened"* (line 259) by the people she requested help from. Jane's world fell apart when she drank following a period of abstinence; her young son was removed from her care and she is told by a social worker "*you're a drunk, we're gonna take your son off you, get him adopted out, he's at that age, your family are fed up with you"* (line 109-10). Kayla sees her young daughter becoming someone who cares for her when she is ill from drinking and does not want to put her through this any longer so called social services to say, *"you need to take my daughter"* (line 73). Cara was a new parent feeling "*isolated"* (line 109) and *"anxious"* (line 110) her drinking persisted and things continued to get *"worse"* (line 266) until she felt *"very broken"* (line 264). Her life *"crashed down"* (line 267) resulting in referrals being made to social services.

Jackie described her life as *"chaotic"* (line 950) as her drinking increased in an abusive marriage. The *"fateful"* (line 296) event that alerted social services was Jackie's own aggression toward her child that caused her family to call social services when she threw a plate "*so I picked it up and chucked it back and it hit him"* (lines 297-8). Gillian's support came from her father but he did not know how to help her, when he died she had no one to turn to and she became *"more depressed"* (line 281) and *"took more and more drugs"* (line 281) after her children were taken into care.

4.3.1 Overwhelmed and needing support

This theme captures difficulty with coping in the context of relationships with partners, children or bereavement. Most of the women talked of needing support, feeling anxious and depressed, or being in relationships that were violent and controlling which affected their wellbeing.

In the period leading up to social service involvement Kim, Nicola and Cara actively sought support from their doctors as they felt their emotional/mental health worsening in relation to their children and their inability to cope:

> *"I went to my G.P. for some help 'cause I didn't know where to turn to, I couldn't cope with the children, I couldn't cope with what was going on within me" (Kim, 44-46).*

Kim stumbled over her words and took a deep breath when talking about her need for healing which brought to the interview encounter an essence of her experiencing back then and her desperation:

> *"I wanted some support, some help, erm you know to get over the rel…ationships I'd been in (in-breath) and start healing I suppose but at that time I didn't know the best way to go, go forward, but social services did seem like the only way forward at the time" (Kim, 56-60).*

Cara described isolation which seemed to envelope her mental and physical space. Her drinking and anxiety levels increased post pregnancy suggesting these issues were present for some time and she seeks support in the context of motherhood:

> *"I had my first child in* (year), *I was living in you know quite an isolated place and I was drinking a lot. Urm, the drinking escalated and my anxiety levels were really, really high. Urm, I think it got worse after having the baby. I informed the health services of how I was feeling" (Cara, 108-112).*

Nicola, too, sought help from her doctor; she felt trapped in her new life as a mother, experiencing feelings of anxiety and depression:

> *"I just had this child, I felt I wanted to escape him, erm and then I started drinkin…I suppose as the years went on and I started drinkin more, erm the anxiety and the alcohol together, I started to turn up at the doctor's and say I was depressed or I was feeling anxious" (Nicola, 43-47).*

Jane talked of a controlling and violent relationship with the father of her daughters, that initiated her use of alcohol, but continued after the relationship ended:

> *"Err, when we split up I continued drinking to help me sleep and don't know it's like I just crossed that line where I was drinking 24/7" (Jane, 40-41).*

Jackie spoke about her violent marriage and the effects this had on her after sixteen years. She saw changes in herself and her drinking as time passed, particularly during her fourth pregnancy:

> *"There was a lot of chaos around it, and that for me is when I know that the insanity stepped in because I was drinking two nights a week, maybe three a week during pregnancy" (Jackie, 119-122).*

Gillian's life appeared chaotic due to home circumstances and difficulty maintaining routine. She and her partner were drug users, but she relied heavily on her father who supported her unconditionally. His recent death meant her support and confidante had gone:

> *"…as I said previously my dad had passed away and my father had always been there for me regardless and erm I missed, even though he didn't know what to do he was a form of someone I could off load to" (Gillian, 179-182).*

Kayla was eighteen and already in need of support shortly after the birth of her daughter, being an adoptee herself, there was a history of service involvement in

her life. She was living in a supportive residential home as there were already concerns around her drinking:

> *"…they said I suffered from postnatal depression, erm they stayed watching but because I was doing everything a mother should do they weren't really worried because I was on antidepressants" (Kayla, 55-57).*

This subtheme captures the women's experiences of chaos and trying to cope in contexts of abusive and controlling relationships, motherhood, mental health issues, and addiction. The themes of feeling trapped and isolated permeate their narratives as the relational dynamics of each woman showed a disconnection with their families or personal relationships. There seems to be a need in many of the women to be heard as they approach services or their behaviours begin to speak for them.

4.3.2 Instability draws attention

This theme signifies the events that led up to social service involvement in the lives of the women. There are strong themes of chaotic lives, violence, aggression, and addiction problems while parenting which began to present risk, as attempts to cope started failing. These risks appeared to have been present for some time and they become noticed by various others including school and nursery as they escalated. Cara described feeling broken and used a metaphor of broken plates to describe her world before any action is taken:

"I was just (phew) very broken it was awful, the police, every night there was some chaos, some drama and it all happened because it got worse. I would say it was like you know when you're spinning all these plates in the air and all of a sudden, they crash down. That's what happened" (Cara, 264-268).

She found it strange that she was not confronted and Cara had a strong theme of her drinking being unnoticed or unchallenged throughout her interview:

"The thing which I found quite strange was they didn't pick me up on it when I went to get him, they didn't say 'no you're not taking the child, you're drunk' they just let me go with the child and then phoned social services" (Cara, 160-164).

Jane's drinking is noticed by staff at the nursery as she dropped her son off before going to work, they do not confront her, but call her mother to collect him later that day. Jane struggled to recall the series of events clearly but her family contacted social services later that day:

"When my son was six months old I picked- up, erm which was just the one, which I thought was just the one drink, err I dropped my son off at nursery and I don't remember much but that's when they became involved" (Jane, 74-76).

Kim was already receiving involvement from social services prompted by a previous disclosure to her doctor about her situation and need for support. Childcare was being provided as a result but she was unable to follow through with her good intention showing a loss of control:

"I didn't pick the children up, I wasn't there when they came home from school, erm I'd gone to town, all good intentions to buy some coats, to buy some winter coats for the two boys and ended up spending that money on drink and drugs" (Kim, 88-90).

Nicola's help seeking through her doctor led to a referral to an alcohol service whom was obliged to inform social services:

"They said they would have to tell social services that you know I was a parent and I was drinking, but it was the alcohol service" (Nicola, 82-84).

Some of the women become known to services through acts of aggression or violence, perpetrated by themselves or others. Gillian stated her home was under surveillance by the police due to suspected drug dealing. There was a stabbing that took place at the home and her object of concern was for herself:

"…my fear was about being caught with the drugs and no concern for the person's welfare…erm needless to say social services and police were called" (Gillian, 82-84).

Jackie was living away from her abusive and violent husband but, after sixteen years of marriage, the violence had continued to influence the way the family related to each other and a lasting hostility when referring to him:

"On that fateful morning, my second son had picked something up and chucked it at me so I picked it up and chucked it back and it hit him so my daughter picked up the phone and told her dad. So (sarcastic voice) daddy phoned social services" (Jackie, 296-299).

The phone call was acted upon the same day:

"Social services came later that night with child protection and I'd had a couple of drinks so basically they said, 'we're taking the kids into care', so that's what brought it to a head" (Jackie, 300-303).

Many of the women in this subtheme were experiencing an inability to self-regulate and manage their impulses. There was an instability in the women, created either by their central concern being taken over by their addiction, or a complete inability to perform daily life tasks, such as collecting children from school or nursery. This ultimately ended, in all cases, with alerts being made to services, as their focus had been overridden from their responsibility to their children. Most of the women had lost the ability to self-regulate, losing control over their lives, and their substance use. All, but one of the women, had experienced trauma in childhood and/or adulthood and demonstrated an inability to self-regulate that may be consequent of low personal control in these situations.

4.3.3 Harsh reality

This subtheme captures the experience of services becoming involved; and the process of children being removed from the home, or placed on the child protection register. There was a sense of abandonment for most of the women as they experienced the harsh reality of having parental roles cut without support. There was a strong sense of a reality, particularly on Kim, that seemed like a drawbridge being raised with no possibility of being lowered, as these consequences were given with no further direction or support. One woman felt threatened, while another took control by absconding and running away from the situation, but overall, there is a deep sadness behind the anger and confusion as Gillian talked of the effect this had on her daughter, when she said goodbye to her children at their school:

> *"Needless to say, I was all over the place and devastated, I could not believe this was happening to me, my family at that time. Urm, my daughter said to me age ten, 'don't worry about me mommy, I'll be fine, I'll just look at it like I'm going on an adventure'" (Gillian, 122-125).*

Gillian contrasted the different coping styles of her children, as her daughter and son both respond differently to the separation. Her daughter escaped into a fantasy world, telling her mother *"Don't worry about me…I'll just look at it like I'm going on an adventure" (lines 124-125)* seeking to protect her mother's feelings and being compliant, while her son protested, fought, and eventually shut, down implying the different attachment styles of her children. Gillian experienced shock, denial, and

distress in relation to her situation and the loss of her children, as the effects are felt by all involved:

> *"The girls seemed to manage reasonably well and a lot better than my youngest son did, he became really withdrawn, wouldn't talk, wouldn't eat, erm the day they took him from school, erm he was screaming and crying and he kicked and bit the social worker, erm I was distraught because it was my son's birthday and he'd got a cake at home and everything and…" (slow pace) (Gillian, 154-159).*

Gillian describes her worsening situation shortly after and the psychological impact:

> *"Needless to say, when they were first taken it was a case of I'd just become more depressed, took more and more drugs and the only time I made any effort to do anything was when I had contact with the children" (Gillian, 280-283).*

Kim talked about the events following her failure to collect her children from school and the seeming finality of her parental responsibilities:

> *"Social services phoned me and told me not to go near my two children…if I wanted to go to court that day I could but there would not be a magistrate in this country that would give me custody of the children. Erm so from then they were taken into protective services" (Kim, 97-100).*

She described the aftermath of these events and the reinforcing message of her lack of value as a human being, and not feeling supported, which is a theme she

described throughout her story. The message she receives from social services is clear, addicts just want to use:

"So yeah, from then on there was absolutely no intervention with me, it was just point blank (harsh voice) 'we're not interested in you, you can go off and do whatever you want you know, it's all about the children'" (Kim, 122-124).

As for Jane, she experienced a visit to her home after concern was raised about her drinking by the nursery and is shocked by the police presence:

"They came round and she the lady came round with a police officer (raised and surprised voice) err saying 'that my son was took away, that they were gonna get him adopted out, he was at that age he could be adopted" (Jane, 102-105).

Jane continued, and the anger she felt is still evident in her voice today in the context of receiving no support, which she repeats a number of times. This repetition brings her experiences to the fore, her processing of the fact that "no support" was given to her stands out in her mind and this injustice continues to fuel her anger:

"So literally they were telling me (anger-raised voice) no support whatsoever, literally they were just saying 'you're a drunk, were gonna take your son off you, get him adopted out, he's at that age, your family are fed up with you'…no support no nothing, no nothing" (Jane, 108-111).

Cara describes her experience and lack of visual presence as confusing:

> *"What happened to being with was they phoned me up and said, 'we've had blah, blah, referrals about you, you just need supervised access' and that was it nobody came to see me, I was like what does that mean?" (Cara, 176-179).*

Again, she is confused over the process of involvement and the mixed messages she received about the seriousness of the situation yet boundaries seemed fluid and lax. Cara presented with themes being unnoticed, unchallenged and her needs not being recognised throughout her narrative:

> *"We didn't understand why they were put on the child register when they were with my partner…'cause they weren't in my care…and again it was unclear because they were saying 'aww…they can come and stay with you if you're ok'* [not drunk]*" (Cara, 209-214).*

Nicola had sought support for her drinking and been referred on to social services but found a lack of understanding for her addiction problem:

> *"They didn't understand it and I think their way of trying to help people be sober was I felt quite threatened and you know if you drink again we're going to take your daughter away" (Nicola, 256-260).*

Kayla has two experiences of her children being adopted and although she did receive some support with her daughter, her son, the second child was forcibly taken

from her at birth. Initially Kayla sees the effect she is having on her child and this concerns her, she seems to speak from a place of knowing, seeing parallels in her daughter's experience as similar to her own, she also grew up with an addicted mother before being adopted herself:

> *"She went to the fridge and got the cider out, got a flannel and put it on my head and that was the last straw. I thought nope, I'm not doing this to her, she deserves better…I phoned up social services and I said, 'you need to take my daughter'" (Kayla, 68-73).*

Kayla has a very different response to her son being forcibly adopted and no opportunities being offered to her, she disappears for three years:

> *"They didn't give me a chance, they said 'no we're taking your son off you' so I just went* ***what for*** *kind of on the drink and drugs, it was kind of like I don't care, I've lost everything and I just went on a major binge and disappeared (laughs) from social services" (Kayla, 85-88).*

Kayla uses the term of going "what for" at this point and preceded to inflict severe pain on herself by disappearing into a prolonged period of drug and alcohol use. Her laughter, although not explored directly, appeared to be a defence mechanism while recounting a situation that was unbearable to her. Her ultimate control in a situation where she had none was to remove herself from the proceedings.

This theme represents the feelings of the women during the process of children being taken from their care or having their children placed on the child protection register. Most of the women felt unsupported, that they were not given options of what they could do to improve themselves and the lives of their children. All of the women have addiction problems and this is further exacerbated as they attempt manage the emotional pain of their situations. There are reactions of shock, disbelief, depression and a sense of aloneness as they appear abandoned once the children are safe. There is a higher level of stigma attached to addicted mothers that is shown is some of the comments made to them but does not seem to be followed up with support once the children are gone which is the major factor of concern in the first place.

The superordinate theme ‘World comes crashing down’ represents the women’s life worlds that were characterised by abusive relationships that had damaged their sense of self and/or feelings of sever anxiety and depression that became apparent in the context of their children and being a mother. Help was actively sought by a number of the women or their increasingly erratic behaviour drew the attention of services. The discourse of social services was to focus on their addiction rather than their mental health needs or wider dysfunctions coming from their past and present relationships.

4.4 No place for you

This theme communicates that the central concern of social services were the children but as these children are connected to their mothers and ultimately the vast majority of these children return to their care there are implications to this narrow

focus. This exclusion that many of the women experience during these processes further compounds their sense of being alone and having to find their own way to wellness. There are periods of falling apart, increasing addiction and worsening mental health before help is offered or children are permanently removed as there is no place them or their concerns.

4.4.1 It's not about you

There is a lack of place for the women in these processes. They feel they are blamed for their 'self-inflicted' addiction and cast side or completely excluded. They experience poor consideration of life circumstances that affect their functioning as women, parents and human beings that leave them experiencing themselves as outsiders that are manifest in poor communication, and linking up to support services for the women that consider the needs of the family unit.

Kim experienced a strong sense of being let down by services which is apparent in her tired and deflated tone as she spoke of her difficult situation that was not acknowledged:

> *"I was living with an alcoholic having an alcoholic's baby, do you know what I mean, there was just no, you know (deflated tone) there was just* [I] *felt pretty let down by them and they categorically said they weren't there for me they were there for the children's sake" (Kim, 527-530).*

She continued to describe her sense of being overlooked as her needs were not considered outside of the needs of her children:

> *"A bit of childcare but there was nothing on the practical side of you know, me giving up the drink and drugs, you know that was left to me to deal with" (Kim, 423-424).*

Cara was directly informed that her needs are not included even though they related to her children and is seen when she corrected herself:

> *"I asked my social worker, the kids social worker for help finding somewhere to live so when I was sober I could live with the children and she said, 'I'm not here for you I'm here for the children'" (Cara, 304-306).*

The impact of being unsupported left a sense of being blamed and feeling that she was nothing:

> *"She treated me like I was nothing and I'd brought this all, maybe on myself, I just felt I didn't have any support" (Cara, 313-314).*

Jane reflected back and was better able to articulate her sense of being unsupported back then and her dependence on alcohol. This caused her voice to falter as her experiences were brought into the present:

"I'm being completely honest you know before I used to go to the case conference I'd still have a drink, erm so really I was doing everything wrong (voice breaks) but they weren't, I wasn't getting that support, what I know now and what I knew then, I felt alone, trapped and no one understood me" (Jane, 196-200).

Gillian experienced void that was not backed up with any support. This left a sense of something missing, that she needed supporting in her own right:

"I don't feel that regarding social services that they, for my partner or myself that they gave, you know it was just like they came and they took the children. They said there'd be a court hearing, there was no back up" (Gillian, 254-257).

Kayla experienced being completely shut out of all involvement. She was not invited to any proceeding as her son was swiftly placed for adoption from birth:

"They didn't even let me go to them, they didn't tell me about them or anything. They just went bam! There you go, taking your son off you, job done" (Kayla, 488-490).

This subtheme speaks of the isolation the women experienced in relation to their involvement with social services. There is a clear separation of the child's needs that that does not include the mother or her needs placing the women outside and deepening their sense of isolation and lack of support.

4.4.2 Sense of aloneness

This subtheme speaks of the sense of aloneness the women felt even when support was received there was still a sense that something was missing leaving a feeling of dissatisfaction that was described by Kim as damaging:

> *"I didn't have a key worker, I didn't have a social worker working with me it was just about the children and that was quite damaging the way the children were brought back to me and yet there was no work done on me" (Kim, 520-522).*

It seemed Kayla had no one to support her as she went through the process of her son being adopted against her will. The presence of an intergenerational cycle of addiction appears to be repeated as Kayla herself was adopted as a child due to her mother's addiction from which she has never recovered. She stated:

> *"Erm, the only support I had was my birth mom but she was not very supportive because she is an alcoholic and an addict" (Kayla, 458-459).*

As for Nicola, she had maintained a period of abstinence during her time on a day programme at the addiction service but when this ends she drinks again. She described feeling lost and finding it strange not having to attend any longer:

> *"As soon as I left there I started drinking straight away even though I had pretty much six months of sobriety…When I left there I just kind of felt lost again which is really weird but it was difficult not being there anymore" (Nicola, 221-225).*

Gillian felt a sense on aloneness once her children had gone; she spirals down further as she now lacks something to hold on to:

> *"My drinking and drugging spiralled more out of control after they were taken, it was just like there was nothing, there was nothing" (Gillian, 242-244).*

Jackie on the other hand felt alone when she returned home with her son as the actions agreed by social services did not materialise. She begins to feel like a number as her experience is felt as dehumanising:

> *"You're just a number and when I came out of the mother and baby unit and came back here, everything they promised to put in place did not happen, out of sight out of mind" (Jackie, 574-576).*

Jane talks of past experiences of feeling alone with present understandings and again offers hindsight of what she needed then. Her desperation was subdued with medication and her voice became emotive with her realisation that she was not directed toward treatment and was left to find her own way:

> *"My G.P. was really good with me but he kept throwin diazies* [diazepam] *at me, you know do it yourself. (voice raises) You know at no point did anyone say to me there's a treatment centre…I was so desperate if they'd have offered it me I'd have done it but in the end, I had to do it myself" (Jane, 473-477).*

This subtheme captures the women's experiences of feeling alone even when support is in place. This is because support is not provided or endings are abrupt leaving the women to their former sense of being alone. There is a lack of understanding experienced for the needs of the women and support that does not go far enough. This leaves them feeling marginalised or further damaged through prematurely retuning children without addressing their presenting needs.

4.4.3 Falling apart

The women described their experiences of disorder and chaos as the structures that maintained their former functioning were removed. There was a deepening lack of stability in their lives which drove them to hold tighter to that which was familiar, their substance. Cara described a form of relief as her ability to present an organised front fell apart and unravelled:

> "*You know the court and everything was unravelling, I'd done so well over the years keeping it a secret (laughs) and holding on and it all just you know was out in the open and you know to be honest it felt like a relief, it was out in the open and I thought I don't have to hide it, I can just drink now" (Cara, 665-669).*

Jackie also expressed relief as she exposed her inability to cope in the only way she knew a disorganised and chaotic self:

"I can't tell you if it was a relief or what but there was a scream, I was screaming help and I reached out for help in the only way I knew, through chaos and alcohol, I knew I wasn't coping" (Jackie, 493-496).

Jane had lost all ability to present a functional front and this was shown by her nonattendance at child protection meetings as she was unable to face what was happening:

"I didn't go to case conferences but at this stage I was well into drinking and taking other substances. So, for six months I was in and out of blackout, erm, I never attended the case conferences" (Jane, 228-231).

Kim acknowledged that her children being returned to her was wrong as during their time in care she had declined further. Her description of relating showed her inability at that time to relate to people as her relationships were with violence and substances:

"And they did eventually come back to me after about eighteen months. Which wasn't [a good idea] *'cause I was into relating the time my children weren't with me, I got into another violent relationship, another drinking relationship, drugging relationship" (Kim, 129-132).*

The uprooting of Gillian's children had left her with no structure of normality. She acknowledged her failings as a parent but spoke of the life structure that children and parenting had provided. Again, she fell further into what was familiar her addiction:

"The last three years was even worse you know with the kids being gone, they kept me you know, as much as I wasn't a mother to them, they kept me in some kind of, I wouldn't say I was consistent but some kind of consistency if that makes sense" (Gillian, 462-465).

Kayla also fell into despair and sought oblivion in alcohol as she felt herself losing her mind:

"I went back on the drink full force 'cause I couldn't cope with it, sent me doolally" (Kayla, 482-483).

The subordinate theme 'Falling apart' represents the worsening state of the women once their children were removed from their care. The loss of structure that parenting brought to their lives and identities as mothers drove them further to cling to their substance. This increasing use of drugs and alcohol, in the absence of their children, widens the gap between them and their children as behaviour, chaos and unsuitability to parent was further demonstrated.

In summary, the superordinate theme 'No place for you' speaks of the women's needs being marginalised within the social service framework. Direct comments were received by some of the women that made this message clear and they were left unsupported. When support was offered this did not go far enough and women returned to feelings of loneliness as follow-up care was not available. There is a distinct message from the women as they all continued to fall deeper into chaos

and dysfunction with the weight of addiction which serves to express their increasing needs that continued to be unmet.

4.5 Change as a psychological journey

This theme captures the psychological process of the women as they embarked on their “Journey of change”. The subordinate themes of ‘Speaking a different language’ and ‘Letting down the barriers’ show the stages of these early processes as they began the journey of being open and honest about themselves that addiction services themselves were not always able to facilitate to the level or period of time needed.

4.5.1 Speaking a different language

This subtheme captures a deeper understanding of how language is interpreted between the women and the services. The language of controlled drinking is either rejected, leaving them in a position of needing to lie to conform to the help offered and finding services unhelpful or facilitating their desire to continue drinking. There are also mixed messages where Nicola found her striving for abstinence was undermined in an environment that did not facilitate this or as Kim found her long term support did no prepare her for going it alone.

Jane explained her experience:

> *"I went to* (Alcohol service) *where they said I could probably reduce with a drink diary and I told them that was not possible, I had to be completely abstinent" (Jane, 164-166).*

Jane showed an awareness of her inability to self-regulate her alcohol intake which was met with a response that did not fully comprehend this. The effect of this miss match of goals impacted her treatment. Jane appeared to be bending to fit a provision of service that she believed did not suit her needs. The approach of controlled drinking though managing unit intake caused their relationship to be built on lies and dishonesty about true feelings:

> *"I had a support worker who literally, looking back at it, I used to lie to her, she'd say 'how are you feeling?' 'I feel great (smiles).' I didn't feel great you know. 'Have you had a drink? You know you are allowed three units.' Yeah I've had three.' Three bottles (raised voice) everything was a lie, I was lying to myself you know erm and I was still drinking" (Jane, 188-192).*

As for Jackie, she received similar information about controlled drinking and she admitted she did not want to stop. Jackie is in a position of blaming, which serves to protect her drinking position, as she has not yet come to fully understand the nature of her drinking problem and the distraction it provides from her own traumas which she is not offered support for if she opts for abstinence:

"I'd got the addiction service saying I could probably learn to control it, 'cause they said, 'do you want to give up drinking?' I said, 'well no not really.' I was still in that blame, I didn't know I was an alcoholic, erm, they said I could probably learn to control it" (Jackie, 364-368).

Kayla found the message of controlled drinking unhelpful and goes on to say:

"Telling you, you can control your drinking, you can't if you're an alcoholic or an addict. You can't control your using or your drinking, it's just that you are powerless over the stuff, that's why you want help" (Kayla, 761-763).

Nicola had to engage with a daytime programme and although she had found much of this beneficial, there were aspects of the service that made her situation more difficult as people were at different levels of change:

"I had to engage with the services you know and it wasn't always easy, sometimes I'd be in groups where people were active you know, they were dinking in the break, they'd drink on their way in and when you're trying to be abstinent it wasn't very helpful" (Nicola, 265-269).

Nicola also expresses a feeling of not being heard during her one-to-one sessions. The effects of this are a closing down of her capacity to be honest; again, aspects of the service itself were not facilitating her readiness for change as the therapeutic alliance was lacking:

"I didn't really get the sense she was really listening to me so I didn't feel like being honest with her. So, I was just like 'I'm great' I'd walk in like 'I'm great yeah, I'm not drinking.'" (Nicola, 401-404).

The women appear to be sensitive to the language services use such as 'control' and 'lapse' or the environment promoting abstinence while people are under the influence of substances. These become mixed-messages, and Cara recalls her ability to hear what she wanted at this time, reinforcing the importance of language used in the detox relapse prevention group. She is drawn to the distinction made between a lapse and relapse, and refers to this as 'gold' as it signifies permission to drink:

"In the detox centre, they do a relapse prevention but they say…which was like gold for me, was they tell you, you can have a lapse, there's a difference between a relapse and a lapse. A lapse it like 1-2 days and then that's in your head 'ding, ding' (bell sound.) Oh so I can have a lapse then, that's fine" (Cara, 909-913).

Kim had a longer period of abstinence and this remission of her symptoms meant support was reduced but as the support reduced she fell back again into addiction:

"Obviously when things were on the up and I didn't need so much intervention and I didn't need to see my key worker and this is after a couple of years, you know that's when I fell through the loop again and erm I picked up" (Kim, 487-489).

This theme captured the willingness of the women to engage with addiction services but how this engagement can be hampered through service structures and modes of support that were unable to facilitate long term change. At times the services were not able to meet their needs as if they were speaking a different language.

4.5.2 Letting down the barriers

This subtheme captures what most of the women described as an opening up to others, finding their voices and beginning to talk honestly about how they feel. This is facilitated though a developing trust in some other person or group. They overcome former anxieties about discussing a spectrum of feelings, including parts of themselves that had remained hidden, or simpler, negative feelings about the daily drudgery of life. Nicola noted that having her honesty recognised was beneficial as it propels her towards change:

> *"We appreciate you being honest with us, so even though my life was still a mess and I felt really crap about everything I still get that well you're doing something good 'cause you're being honest and that's something I found really difficult to do, be honest" (Nicola, 570-574).*

Gillian carried a lot of distrust and weariness of people stemming from her trust being broken as a child. This kept her in a place of silence and shame but this begins to change:

"Being more open…I'd still say I'm wary of people, I think it's natural to an extent. I am more of an open book today. I'm not ashamed of where I've come from, whereas I used to be ashamed" (Gillian, 719-722).

Kim contrasts her two involvements with social services, first time being all alone and the second as facilitating change through contact with others and open discussion of problems:

"We would have group therapy and talk about our addictions…and I didn't feel as isolated. The first time round I felt isolated on my own, that's why I never got my life together you know 'cause I was on my own, my kids were removed and I'm all on my own" (Kim, 445-448).

Again, Jane highlights her reluctance to be honest for fear of it being used against her but now she has access to people she can open and honest with:

"I was scared to tell (addiction service) *how I really felt in case they told social services but now I've got a phone full of people I can ring and say…'I'm having a bad day' and they're like 'ok, I'll be there in half hour' (clicks fingers). Let's go to a meeting, let's go and have a coffee, straight away I feel better" (Jane, 643-646).*

Cara credits her long-term change and sobriety as being founded on her time in residential treatment:

"Rehab was the best you know 'cause as a result of that I've been sober nearly four years" (Cara, 725-726).

She continues to identify particular changing points that were based in honesty, trust and self-disclosure:

"After step-five [part of a 12-step programme] *wow I just felt amazing. I was in a room with someone who I trusted and I trusted them wholeheartedly and I did tell them everything, there was nothing I kept to myself and we were there for maybe five-six hours and that was a turning point for me as well I think" (Cara, 938-942).*

Kayla emphasises the need for complete honesty too:

"Just getting honest and I've been completely honest with my sponsor, she knows everything (emphasis) and I mean everything" (Kayla, 835-837).

The subordinate theme 'Letting down the barriers' describes something the women began to find beneficial to their change process. Some of the women had deep seated distrust, which will be discussed in the following pages, yet they began to open themselves to another person. The developing trust began to form connections to another human being and the process talking about how they truly felt ranging from the daily mundane to their long held deepest selves.

In summary, the superordinate theme ‘Change as a psychological journey’ represents the conditions the women found either helping or hindering to their change process. The subordinate theme ‘Speaking a different language’ represents experiences of addiction services and the women not meeting on the same psychological level. This resulted in either their desire to continue to drink being sanctioned or the women feeling the need to tell lies to adhere to service methods of control. Lying was counterproductive to change as the majority of the women state that honesty, trust and disclosure about their true selves facilitated their change in connection to an understanding other as they let down their defences.

4.6 Trauma and transformation

This theme captures the back story of the women, whether their traumas were a result of their situation at the time or were founded in childhood, all of the women expressed psychological difficulty in relation to others. This is described in the subordinate theme ‘Abusive cycles.’ The second subordinate theme ‘Changing through connection’ describes the healing effects that occur as they connect to others and transform their lives.

4.6.1 Abusive cycles

This subtheme captures the backgrounds of the women and a number who disclosed childhood sexual abuse. Others described the suicides of family members, attempts to take their own lives, or growing up in violent homes and recreating this ‘norm’ in adult life. Only one woman did not share any information of trauma in relation to her

family but she did experience a suicide attempt as her mental health issues became intolerable and she sought escape inferring a predispositional vulnerability that was activated through psychological, situational, and/or biological factors.

Kim alluded to a traumatic background as she briefly disclosed her own childhood abuse in the context of her son being placed with her abuser by social services:

> *"Which wasn't the best set-up because my grandfather had molested me as a child so I told social services what the risks were you know" (Kim, 106-107).*

Kim described a period of her life that is abusive on many levels. Not only is she managing her addiction and children but she conjures up a situation filled with danger. As someone who was abused in childhood she entered a life where abuse continues until she is able to escape from this relationship:

> *"I was erm prostituting and I had a pimp, and I had a drug, amphetamine problem and alcohol problem and things got really risky and dangerous. The relationship was very violent, erm I managed to get out of that relationship" (Kim, 36-39).*

Jackie, too, talks of recreating childhood experiences in adulthood in the sense of creating a veneer of idyllic family where violence lay beneath the surface:

"I was in a marriage that was abusive and violent but looked fine on the surface. I very much recreated my childhood in adulthood where everything looked wonderful on the surface. There was no alcoholism is my childhood but there was violence" (Jackie, 62-66).

Cara's suicide attempt resulted referrals being made after seeming to go unnoticed by those around her, her behaviour becomes more extreme. She did not want to die but she did want the chaos and turmoil in her mind to stop:

"[I] *wasn't trying to kill myself it was my head…I just wanted everything to stop' (Cara, 509-510).*

Jane describes coming to consciousness in a hostel, her life deteriorated rapidly once her fourth child had gone to live with her sister. As a woman with a professional career as a nurse, she had now experienced homelessness, police involvement, and was living in a hostel. Her thoughts when coming to were focused on her impending withdrawal symptoms as her disorientation eases she realised her need for her family:

"I was admitted to hospital several times…I tried to commit suicide several times, all I remember is coming around in a hostel…thinking I was sober, I was in withdrawal thinking where am I, where's my children, where's my mom" (Jane, 242-245).

Nicola is suicidal but reflects on the impact that suicide has had on her family. She has experienced family members take their own lives, one of whom battled with addiction problems, her identification of herself as selfish in her addictive behaviour pulls her back from these thoughts. Her voice softens as she considers the effects this could have on her children and family she does not want them to experience further devastation through her actions:

> *"I wanted to die but even though I was really selfish I just thought you can't do it to them (voice softens) it's not their fault, to my children and family. I thought we'd seen two suicides in my family, one of them was an alcoholic, threw himself under a train and the other hung himself. My uncle and my son's grandfather within six months of each other so I've seen the pain and devastation caused by that" (Nicola, 481-487).*

Kayla had lost her belief in love as the concept of love had been destroyed by those who were meant to love and protect her. This was replaced with hate and anger that, in turn, would take from her what she loved – her children:

> *"I thought there's no such thing as love, I thought if you love someone then why would you do that. Erm, then it's cause my parents didn't do anything about it, I got annoyed with them, I hated them for it. So, I had a lot of hate, lot of fear, lot of anger and it just came out side wards" (Kayla, 94-945).*

> *"Is this sexual abuse?" (Researcher, 955)*

"Yeah, sexual, physical and emotional, the whole package" (Kayla, 957).

"It was my brother" (Kayla, 961).

Deep rooted distrust of people stood to jeopardise Gillian's place in residential treatment as she was too guarded to fully engage in groups. Her survival strategy of locking her inner self away was working against her as her superficial engagement was noticed by staff:

"I was just doing the minimum as I could, just to hang on in there. I was still very wary of people, I didn't trust, I didn't want to share my inner most anything with anybody" (Gillian, 554-557).

I ask Gillian about her lack of trust as the sense of abuse was present:

"Where does that distrust come from?" (Researcher, 569).

Gillian's trust has been lost in childhood leaving her with a defensive strategy of 'trust no one' as she emphasises the effect of having trust broken in her family:

"Childhood, being abused, erm sexually, physically, mentally by someone who I was supposed to be able to trust. And when that happened I lost trust in everybody not just that person it was everybody (emphasis) couldn't trust anyone" (Gillian, 575-578).

Abusive cycles capture the back story of the women that goes some way in adding understanding to some of their difficulties. The styles of relating to others for some of the women become more apparent in this context. For example, Jackie's aggressiveness is not only something she expressed in her relationship with her children and toward social services but is something she grew up with and recreated in her adult life. Also, the effect of Gillian's childhood abuse that broke her trust impacts on her openness to receiving help. Kayla learnt to defend herself with anger when feeling threatened which had been the theme throughout her story but is more understandable in the context of its origins.

4.6.2 Changing through connection and hope

This subordinate theme discusses what the women found to be important aspects that contributed to their change. For Kim, she identifies hope and reconnection and there is a distinction made between open and closed doors as feelings of being mad and defective and relieved through connection and hope:

> *"I've always been knocking at doors and thinking I was mad or there was something terribly wrong with me and I think when I walked through the doors of AA Alcoholics Anonymous I kind of got that connection again and that hope" (Kim, 674-677).*

She continues to describe her contact to ongoing supports that emerged out of a chance encounter with an acquaintance and laughs showing contentment at finding a place for her:

> *"I just knew she was going to some kind of meetings to help with alcohol problems and erm she asked me if I could get to a meeting and gave me the times and venues where they were. I got myself to the next one which was on a Friday morning and I've been going ever since (laughs)" (Kim, 699-702).*

Jane has a similar encounter of being directed towards a place of support and counts herself lucky. She connects with other women and opens to other means of connection in the church too:

"With the support of my support worker at the hostel…luckily for me he was on a 12-step programme…so he knew about addiction…he gave me all the information of the meetings in (location) *and erm I started going to church, I went to my first meeting and got to know a few of the ladies" (Jane, 302-306).*

Jane critiques her experience with social services from a position of hindsight, while acknowledging her failings to her children, there was a lack of knowledge sharing on the part of social services:

"I do feel I put the drink before my children (hushed voice) before anything but that's all I'd got and the more pressure social services were putting on me the more I drank. If they'd had the knowledge to put me on a programme it would have stopped a long time ago" (Jane, 521-524).

Kayla watches and learns from others. After surrendering in her battle with addiction she sees a new way of being modelled by others and is inspired by their behaviours:

"I surrendered and eventually got to AA, I was watching other people's behaviours and how they acted and how they spoke and I thought I want to be like that, I'd love to be like that" (Kayla, 831-834).

Kayla continues to learn about herself and finds a new self-concept that is based on self-compassion:

> *"It's helped me learn who I am as a person, not all the defects and nastiness that I thought was. I now know that I'm a loving, caring, kind, considerate woman who went through a lot of shit (apologises and corrects self) rubbish" (Kayla, 841-845).*

Cara too embarked on a journey of honest self-appraisal in a supportive environment where this process was shared with others of similarity. The value of this was in the breaking down of her defence of difference and arrogance:

> *"I enjoyed learning about myself even though a lot of it was horrible but the peers were there with you, you know that was positive – the people going through the same thing and the people and counsellors had been through the same thing – so you couldn't like – I was arrogant and cocky so I couldn't say 'you don't know what I'm going through' (arrogant voice) 'cause they had" (Cara, 780-785).*

Visual evidence of change in others maintained hope in Nicola:

> *"There had to have been a little of hope somewhere because in all the times of engaging in the services and going to all the recovery groups I could see people who were not drinking and going to 12-step meetings" (Nicola, 461-464).*

Seeing positive changes in the lives of others drew Nicola's attention to herself and her lack of life progress. This contrast began to show her what was out of reach in her current state and what she wanted to strive for a better future:

> *"Progressing in their lives and there was never going to be any progression in any area of my life, not my mental state, I was never going to get a better job, I was never going to get anything I wanted, I was never going to be able to be in a relationship" (Nicola, 469-473).*

Gillian is first inspired to enter treatment through a chance encounter with someone she had formerly used drugs with. His voice was recognisable to her but his appearance had changed to such an extent she struggled to recognise him. He inspires her to seek help:

> *"What inspired me to go was a guy who I'd used with but I was still using and living on the estate. I was walking to the shops one day and this voice shouted me and I recognised the voice, so I turned around and didn't recognise the person who was calling me" (Gillian, 383-386).*

Gillian maintains her abstinence today with a 'healthy fear' towards drugs and alcohol and interprets her thoughts of using as a need for self-appraisal and connection to others:

> *"I can't say I don't have the thought because I'd be lying to you if I said it never crossed my mind. I'm like, oh where did that come from but it's a healthy fear,*

not a freaked-out fear. But then it's an ok then maybe I need to look at something that's going on and go to a meeting" (Gillian. 1026-1030).

Jackie describes herself as a 'survivor' made possible by channelling her anger toward the system and by working through a programme of recovery she has managed to temper her anger to become her congruent true self. Jackie sees herself as 'privileged' amongst the less 'privileged?' She reframes her anger, which consequently brought social services to her door, as bearing usefulness to her throughout her journey of trying to maintain her mothering life and identity. She describes a coming back and finding of the person she was meant to be, inferring a loss of self, an exaggerated and attacking self, that had evolved through years of domestic abuse which had then transferred to her relating in the home and toward her children.

Jackie describes how these traits, that had become distorted, were 'moulded' and smoothed down to their rightful size through her programme of recovery emphasising a change in her thought process and behaviour:

"I'm one of the privileged ones that was given the survival instinct to bring this to the recovery process because people aren't meant to survive the system. And those patterns of mine, what they used to be, I'm still rebellious (laughs) I'll say it how it is, but those patterns, the 12-step programme has helped to mould and shape [them]*, they're more soberly useful that I can be the person I was meant to be in the first place" (Jackie, 882-889).*

This theme draws out the processes that facilitate change for the women. This happens in relation to others of similarity, people that have similar experiences with addictions and for some of the women this occurs through chance encounters with and direction toward self-help support groups. There is a reorganising of the psyche as they find connection to a group and begin to see what is missing and how they would like to be.

The superordinate theme ‘trauma and transformation’ provides a wider understanding of abuse in the lives of the women. How these unresolved traumas are played out through addiction, confusion, anger, isolation and ultimately, some of the women wanting to take their own lives. This trauma occurs in a place where love, trust and connection do not exist. The transformation that occurs, where the women embark on new lives is embedded in hope and connection. There is a place of belonging and understanding that is found which activates hope and future possibility.

4.6.3 Summary of themes

In summary, the women seem to express their long-standing difficulties, that only seem apparent, through their inability to appropriately parent their children. It appears that, living in an unsupportive and abusive relationship, their difficulties increased and resulted in the use of substances to manage emotions. Extreme behaviours drew attention from concerned others leading to social service involvement. The help and support they needed appear to not be forthcoming from these services and they felt further marginalised and isolated. Their destructive lives seem to change as they meet others of similarity in AA and began building trusting relationships which enable change.

Chapter 5 Discussion

5.1 Overview

The previous chapter presented the findings that emerged from analysis of the interviews. The aim of this chapter is to analyse the findings within the context of current research, literature, and psychological theories. Findings related to the research question will be discussed, within the context of existing literature, including implications to the practice of counselling psychology. This research provides a greater understanding of women who survive against all odds by following the narratives of their experiences. The initial stance of the women being overwhelmed by their circumstances, through to their encounters with services designed for children and not mothers. The services do not provide the mothers with psychological formulations and therefore do not fit the needs of the women, leaving them to eventually connect with other people who can help often through chance encounters.

The findings will be summarised using a relational cultural theory (RCT) therapeutic framework (Jordan, et al., 1991), and theories of resiliency. These frameworks are appropriate, partly due to overarching themes of isolation and connection that are in binary opposition. The RCT model is a positive psychology framework, where individuals identify and amplify their strengths and resiliency through the therapeutic process. Following this, limitations to the study will be highlighted and suggestions for further research will be made before concluding with recommendations.

5.1.1 The importance of this research

The purpose of the study was to explore the experiences of women who have previously had contact with both alcohol and child protection services and resolved their substance use dependence. The qualitative research design and analyses of the data using IPA (Smith et al., 2009) and RCA (Finlay & Evans, 2009) were suited to an in-depth study from the mothers' point of view of experiencing these services in parallel, which is an under-researched area, particularly their longer-term retrospective views. The aim was to understand how these services helped or hindered their ability to live substance free lives and identify sources of resiliency employed by the women. The results contribute to knowledge relating to child protection and addiction service engagement as experienced by those who have lived through these processes. Although a degree of transferability is necessary, important aspects of the experiences will highlight implications for clinical practice.

5.2 World comes crashing down

The superordinate theme 'world comes crashing down' speaks of the lived world of the women during the timeframes before, during, and immediately following involvement with social services. Three sub-themes emerged during these temporal frames and will be discussed individually.

5.2.1 Overwhelmed and needing support

The participants in this study described a ‘toxic trio’ of addiction, domestic violence and mental health which have been found to be present time and again in serious case reviews following a child’s death (Galvani, 2015), but this ‘toxic trio’ is present prior to such tragic outcomes. The presence of the ‘toxic trio’ was also identified at initial and repeat involvement with child protections services in Broadhurst et al.’s (2017) study, highlighting the difficult and complex lives of mothers experiencing domestic abuse, substance abuse and mental health issues.

Literature shows that women tend to define their substance abuse problems as health or mental health problems (Weisner, 1993; Weisner & Schmidt, 1992). Weisner and Schmidt (1992) also found that women with alcohol problems are more likely to seek help from mental health, or general health services, such as their doctor, rather than specific addiction services. This was found to be the case where three of the participants in this study actively sought professional help by reaching out to their doctors and voicing feelings of depression and anxiety in section 4.3.1.

Women face many barriers to seeking addiction treatment, including a lack of support from family or partner (Amaro & Hardy-Fanta, 1995; Grella & Joshi, 1999; Tuten & Jones, 2003), and histories of trauma, including physical and sexual assault (Copeland, 1997; Grella, 1997; Kilpatrick, et al. 1997, 1998; Najavits, et al., 1997). Trauma, physical, and sexual assault which have been identified as overly represented in mothers appearing before the family courts (Broadhurst, et al., 2017), increasing the risk of developing PTSD (DSM-V).

The co-occurrence of PTSD and substance abuse has been shown to reduce motivation for substance abuse treatment; and women with substance abuse problems have been shown to experience greater levels of PTSD (Najavits, et al., 1997), which may form an additional barrier to seeking treatment. Other factors that pose a barrier to women seeking support for addictions are a fear of losing custody of their children (DeAngelis, 1993; Finkelstein, 1994; Grella, 1997), and greater social stigma and discrimination (Copeland, 1997; Finkelstein, 1994; Grella & Joshi, 1999).

The participants' accounts show mental health difficulties (Cara, lines 109-110); lack of coping with internal and external pressures (Kim, lines 45-46); and needing emotional support following abusive relationships (Kim, lines 56-58). Addiction, mental ill health, and domestic abuse described by the women in this study are in agreement with the abundance of child protection literature which identifies such problems in families where substance abuse exists (Cawson, 2002; Cleaver et al., 1999; Ghaffar et al., 2012; Harbin & Murphy, 2000; Humphreys & Stanley, 2006; Kroll & Taylor, 2003; Statham, et al., 2002; Velleman & Orford, 2001).

5.2.2 Instability draws attention

This sub-theme captured the women's increasing instability as their addictions and mental health became expressed through their observable behaviour which alerted the attention of services. The metaphor used by Cara to describe her life during that time was depicted as "spinning all these plates" (line 266), and points to a loss of control and ability to function effectively.

The theme shows the mental health needs of the women, caught up in addiction, abuse, anxiety and depression, which move from the private to the public sphere, leading to social service involvement. All of the women alluded to or described chaotic lives at the point of involvement from social services and all in relation to their children. Concern was raised by day care staff or school teachers as mothers either fail to collect children or appear intoxicated. In one case, the addiction service alerted social services about a drinking parent, and for two others, police were called due to violence in the home.

This shows the pathway to services being alerted in this research and the role of other professionals in the identification of children living with a substance abusing parent. These findings correspond with Cleaver et al. (2008) where a number of sources brought families to the attention of social services from professional and non-professionals. In Jackie's case, it was her violence toward her child that caused police to attend the home. Themes of being noticed by other professionals are evident, yet this is in relation to their children. The women themselves and their longstanding problems are noticed only in the context of their children and not as people needing professional support themselves. The emotions and backgrounds of the women, correspond to those identified by Nehls and Sallman (2005); Rosenbaum (1979); as anxious, ambivalent, and unregulated.

Finally, most of the women experienced difficulty in regulating their emotions and impulses, and the majority had experienced trauma in childhood. The behaviours demonstrated by the women are destructive and inconsistent, signalling their inability

to cope, showing the continuous link between childhood trauma and functioning in adulthood (Felitti, et al., 1998; Taussig, 2002).

5.2.3 Harsh reality

The subtheme ‘harsh reality’ represents the experience of social service involvement that is embedded in confusion, abandonment, shock, disbelief, and depression. The reactions of the women are counterproductive as they increase their substance abuse in an attempt to manage difficult feelings stemming from these traumatic and stressful conditions.

Traumatic and adversarial situations, such as child removal, require a person to be resilient to adapt and face the situation or succumb to depression. The reactions to child removal of women in this study correspond with those found by Broadhurst et al. (2017) where women described an escalation of problems, including suicidal thoughts, self-harm in the form of increased drinking and drug taking, and entering negative intimate relationships. The women in this study, while describing their experiences of child removal, were visibly still angry with the lack of support offered during this period of their lives - it was evident in their tones of voice, and brings forth the reality of services that are child focused to the exclusion of the women’s needs.

Posttraumatic stress disorder (PTSD) can occur following a direct traumatic event or witnessing a traumatic event, of which child removal may be considered. Smeeton and Boxall (2011) found women had difficulty in constructing a coherent chorological story of their experiences of child adoption and not knowing what was happening.

The symptoms of PTSD include an avoidance of distressing memories, inability to remember important aspects of the event, persistent negative emotions such as fear, horror, anger, guilt or shame (DSM-V, APA, 2013). Further pretraumatic factors and gender-related issues have been identified as increasing the likelihood of developing PTSD, and include prior trauma exposure, being female, prior depression, and/or anxiety and childhood adversity (DSM-V, APA, 2013), of which all the women in the present study had experienced to varying degrees.

Poor attachments in childhood have been shown to affect adult functioning by increasing rates of depression, affecting adult attachment styles, and producing destructive ways of managing conflict (Ainsworth, 1989; Styron & Janoff-Bulman, 2009). As attachments are carried into adulthood and form the blueprint of interactions with friends and intimate relationships (Ainsworth, 1989), attachment theory helps provide understanding to the reactions of the women in this study to adversary.

In summary, the theme ‘world comes crashing down’ captures the ‘toxic trio’ that exists prior to involvement with social services and the poor attachments in the backgrounds of the women. As having at least one supportive parent in childhood has been shown to enhance resilience (Collishaw et al., 2007); and the protection resilience provides when faced with adversity (Campbell-Sills et al., 2006). The women show low resiliency, and predisposition to and symptoms of PTSD during and post removal of their children which remains unaddressed by social services.

5.3 No place for you

The superordinate theme ‘no place for you’ represents the experiences of the women in this study during social service involvement. The impact of feeling misunderstood by social services and not being supported leaves them feeling lost in a world of nonexistence as they fall ever further into their addictions. The loss of identity and structure provided by motherhood leads to an ever-increasing addict identity as they experience ostracism from a service that does not understand or take account of their needs.

These three subthemes, ‘it’s not about you,’ ‘sense of aloneness,’ and ‘falling apart,’ will be discussed through a framework of stigma (Goffman, 1963) and loneliness (Hawkley et al., 2008; Peplau & Perlman, 1982; Pinquart & Sorensen, 2001; Wheeler et al., 1983) as these themes run through the experiences of the women and their involvement with child protection services.

Stigma has been shown to impact on the lives of those with addictions and their chances of recovering (Lloyd, 2013). As discussed in section 2.4.4, Goffman’s description of stigma is categorised as ‘discredited’ (those not held to blame) and the ‘discreditable’ (those who are held to blame), in which alcoholism and addiction fall. Goffman states that stigma separates, and makes different, to the point that they are “… reduced in our minds from a whole and unusual person to a tainted, discounted one” (p. 12).

This feeling of being discounted was described by Cara when recounting her experience with a social worker (Cara, 313-314). Kim also describes her experience (Kim, 527-530). These findings add to Forrester et al. (2008) where social workers' responses to vignettes based on typical responses from parents with alcohol problems were recorded. The findings of this study show social workers tended to use a very confrontational and sometimes aggressive communication style with such parents.

Lack of support and understanding was described by all of the women in relation to social services and may be due to stigmatising effects experienced by those with addictions as found in a recent literature review which asks for understanding that addicts are not 'solely to blame' for their condition (Lloyd, 2013). Principles of care for those working with alcohol use disorders are reminded of the stigma and discrimination that accompanies alcohol abuse and that an empathic and non-judgemental manner will aid the therapeutic relationship (NICE, 2011); this was not found to be the approach reported by participants in this study or by social workers in Forrester, et al. (2008) where an aggressive and confrontational communication style was found to be used by social workers in their interactions with parents.

The findings in this study, of the experiences of mothers with alcohol addiction and child protection involvement, are replete with statements of feeling alone and unsupported throughout this process. As discussed in section 2.4.4, people with substance misuse problems are more likely to be held responsible for their condition and be socially rejected (Schomerus et al., 2011), adding to the sense of

aloneness and lack of social support. The protective factor of social support, which has been found to be lacking in the lives of the women in this research, has been found to have consequences for emotional regulation, cognition and depression (Cacioppo, et al., 2006) and suicidal ideation (Goldsmith et al., 2002), which will be discussed further in the final superordinate theme 'trauma and transformation.'

To summarise, the women in this study experienced social service involvement as stigmatising and increasing feelings of loneliness. Although parents have been found to be satisfied with the social worker relationship when respect, honesty, and openness were present, this was not the case where domestic violence and substance abuse coexisted (Cleaver et al., 2008). Considering the impact of stigma on this group and the poor relating styles when social workers are confrontational and aggressive (Forrester et al., 2008), ways of communicating hold an important, extra dimension for this client group in particular.

5.4 Change as a psychological journey

This superordinate theme captures the process of change for the women in this study. The subtheme 'speaking a different language' captures some of the barriers experienced when engaging with addiction services where a lack of psychological formulation results in a poor fit between their needs and service provision. The second subtheme 'letting down the barriers' captures change processes. These two subthemes will be discussed in relation to literature separately before summarising.

5.4.1 Speaking a different language

NICE Guidelines recommend an abstinence based approach for those who are moderately or severely alcohol dependent (NICE, 2011), although findings in this study show a number of women experienced control based support as described by Jane (164-166).

The experiences of addiction services for the women in this study tended to be one of 'speaking a different language' as the services they encountered used language and approaches that do not suit their needs. They fundamentally knew that they could not control their alcohol intake yet services used language that denoted this. As discussed in section 2.5.4, Reading (2009) described three important conditions that need to be present in ROAC, for therapeutic work with addicts, including autonomy, he likened this to attachment theory where autonomous human functioning can develop in secure attachment to others.

The therapeutic alliance was missing for many of the women in this study described by Nicola (401-404). Relational Cultural Therapy (RCT) describes healing in connection as an important factor to harness the healing provided by mutual empathy and the removal of isolation (Jordan, 2000). As described by Nicola (401-404), the lack of mutual empathy shut down her capacity to be honest leaving her isolated and psychologically alone.

Considering the childhood profiles of mothers' who appear before the family courts being plagued by childhood adversity found by Broadhurst et al. (2017), and

described in section 2.4.2, RCT (Jordan, 2000) and ROAC (Reading, 2009) offer a much-needed relational experience that has been shown to provide a corrective experience. The chronic disconnection that develops in relation to a non-responsive parent or an abusive adult relationship may give the message that their feelings do not matter but where mutual empathy exists in the therapeutic encounter the client will see the therapist is touched, impacted and moved showing them they can impact the other and provide a corrective relational experience (Jordon, 2000).

5.4.2 Letting down the barriers

This subtheme shows how the women in this study began to move into trust, honesty and finding a voice to talk of their feelings and experiences in the context of a trusting other or group. Kayla described a process of complete honesty that took place with her AA sponsor where she finally told another person *"everything"* (Kayla, 835-837).

The theme of shame and stigma which appears to promote isolation among the women was diminished through their shared experiences and acceptance in line with Kelly, et al.'s (2017) observation. The result also showed that the empathic response advocated (Jordan, 2000; Jordan, et al., 1991; Miller & Moyers, 2015), might have served as a facilitator of connection for these women. This will lend support to the RCT' principle of mutual empathy where clients can see their impact on the other, know and feel that the therapist is touched and moved by the disclosure, which Buber (1958) referred to as 'I-Thou relationship.' The empathic

response serves to facilitate connection thus reversing the isolation and stigma experienced, particularly by 'bad parents' (Mason & Selman, 1997) and alcoholics (Schomerus et al. 2011).

In summary, the superordinate theme 'speaking a different language' points to the importance of language used by addiction services. When this does not fit the client, it serves to close them off and reinforce their sense of isolation. Although research has found little difference in the approaches used in addiction treatment (Project Match Research Group, 1997), what does affect outcome is the therapeutic alliance (Reading, 2009). These findings are again validated by Miller and Moyers (2015) who suggest "…relational factors such as empathy, which are described as common, non-specific factors, should not be dismissed as 'common' because they vary substantially among providers…" (p. 1).

5.5 Trauma and transformation

This superordinate theme captures the backgrounds of the women in this study, which have themes of violence, childhood sexual abuse, and attempts by many of the women to take their own lives. This theme also identifies what the women in this study identify as factors of resiliency contributing to their change which were based in hope and connection to others of similarity.

5.5.1 Abusive cycles

Three of the women disclosed experiences of childhood sexual abuse (CSA), five described domestic abuse (DA) within their personal intimate relationships, three women made attempts to take their own lives, while others described suicidal ideation. These findings share similarities with those discussed in sections 2.4.1 and 2.4.2 where exposure to multiple forms of harm was found to be present in the lives of all 72 mothers interviewed and having presented to the family court (Broardhurst et al. 2017).

The continuation of childhood trauma into adulthood as described by Taussig (2002) and Felitti et al. (1998) was found to be present for the women in this study to varying degrees. The women who experienced CSA tended to endure more abuse in their adult relationships as stated by Kim (lines 37-39), or as fundamental loss in the belief of love that persists into adulthood Kayla (lines 941-42). Research shows that CSA is a risk factor for further abuse in later life, either physical or sexual (Messman & Long, 1996). The theme of abusive cycles is consistent with research where women who have endured CSA continue to experience physical abuse in their adult relationships.

Further, psychological effects associated with CSA include PTSD, depression, suicidality, anxiety, substance abuse, interpersonal difficulties, and feelings of guilt and shame (Goodman, et al., 1993; Neumann, et al., 1996; Polusny & Follette, 1995; Resick, 1993). Disclosure of CSA was made by three women in this study, two of these were in relation to their children's wellbeing. Kayla did not disclose this information even though it was a key factor in the aggression and anger she

displayed being consistent with research (Goodman, et al., 1993; Neumann, et al., 1996; Polusny & Follette, 1995; Resick, 1993).

Research shows, those who have experienced childhood trauma and/or abuse were 4 to 12 times more likely to experience alcoholism, drug abuse, depression, and attempt suicide compared to those who had not experienced trauma Felitti et al. (1998). Suicide attempts were present in the experiences of three women in this study, either post child removal or as a signal that they were not coping, although suicidal ideation was present for most at different points consistent with Felitti et al's (1998) research. As discussed in section 2.4.2, mothers appearing before the family courts are plagued by childhood traumas (Broadhurst et al., 2017). Dube et al's (2001) study also identified a relationship between adverse childhood experience and suicide risk in adulthood which has been found to be the case for a number of women in this study.

In terms of this research and women involved in the child protection process, it is important to remember these mediating effects. The supressed emotional trauma that they self-medicate may begin to surface once their coping mechanism is relinquished as these suicidal thoughts and suicide attempts emerge at points of crisis. It is at the point of crisis that their means of coping are brought to the fore and identified as needing to be changed without adequate support to do so.

5.5.2 Change through hope and connection

This final subordinate theme ‘change through hope and connection’ speaks to the factors identified by the women in this study as contributing to their change process and will be discussed here in relation to literature and markers of resiliency. The superordinate theme ‘no place for you’ discussed in section 5.1.3 explored the women’s sense of aloneness even when support was in place from social services or addiction services. This theme showed an inverse relationship where hope and connection seem to alleviate stigma and isolation, providing scaffolding where change occurs.

As resiliency has been described as the ability to adapt when faced with trauma or adversity (Alim, et al., 2008; Collishaw, et al., 2007; Feder, et al., 2009), it can be argued that the women in this study have shown resiliency in their adaptation to living substance free lives. Resiliency has been identified as a protective factor against the development of psychiatric symptoms in adults who experienced childhood emotional neglect (Campbell-Sills, et al., 2006). The adults showing greater resiliency, despite having experienced childhood trauma and sexual abuse, had grown up with at least one caring parent (Collishaw, et al., 2007). In the case of this research, the women began to demonstrate a resiliency that was not present previously, and this occurs in connection to others, as stated by Kim (674-677).

Miller and Moyers (2015) reviewed findings from four decades of research on the general and specific factors affecting the outcome of addiction treatment. They identified ‘common factors’ such as therapist empathy and therapeutic alliance as having significant effects on client outcomes but also identified a number of client factors. These client factors included hope (Slesnick, Meyers, Mead, & Segelken

2000); motivation (Longshore & Teruya, 2006; Witkiewitz, Hartzler, & Donovan, 2010) and self-efficacy (Maisto, Connors, & Zywiak, 2000).

As mentioned above, empathy and therapeutic alliance have been identified as having a significant impact on outcome in addiction treatment (Slesnick, et al., 2000). The reconnections identified in the study as being fundamental to change are in stark contrast to the experiences of treatment received through statutory services discussed in section 5.4.1 'speaking a different language' which was replete with disconnect and feeling services could not cater to their needs as no therapeutic alliance had formed. Jordan (2000) describes early traumatic disconnections and how these can be 'potentially derailing' to the healing process (p.1009). Jordan goes on to say:

> *'Each movement into greater trust, closeness, connection, and hope for the trauma survivor, often brings in its wake a whiplashlike movement into traumatic disconnect' (p. 1009).*

The 'whiplash' movement is the consequence of feeling unsafe for the client, thus recreating the familiar relational patterns of distrust where they retreat once again into the familiar and disconnect back into addiction (Jordan, 2000).

The change process identified in this research occurs in connection to another person, a person of similarity. The higher resiliency of those who grew up in trauma and abuse being linked to the protective factor of having a caring parent (Collishaw, et al., 2007), it can be seen here that the connections formed in AA provide an almost re-parenting experience where resilience can emerge and they begin to withstand the

transition into long term abstinence. Terms used by the women in this research to describe resiliency encapsulated hope, ongoing support, modelling self on other people's behaviour, and honest self-appraisal, see section 4.6.2.

The findings of this study support the behavioural mechanisms for change that are mobilised within a social network (Kelly, 2009; Kelly, 2017). Yalom's (2008) group-effect can be seen, where shame, guilt and stigma can diminish through a shared common suffering in an environment of acceptance. The Greek word 'symptom' originally meant 'coincidence, temporary peculiarity' before taking on the meaning of 'sign, warning, distinguishing mark' and finally, being used in the medical sense as a 'characteristic sign of a specific disease' (Schmid, 2005, p. 78). This characteristic or symptom has been further described by Schmid (2005) as a phenomenon, shown by a person. The *'phenomenon of craving'* is used in the text of Alcoholics Anonymous to describe the overwhelming desire to continue drinking after the first drink, a drink which was expected to bring *'ease and comfort'* (Alcoholics Anonymous, 2001, p. xxvii). Therefore, the alcohol becomes the symptom of the problem that already existed.

In summary, the above findings have been discussed within the context of the wider literature. The women in this research all found their means to change through AA where they were able to engage in honest self-appraisal in an environment where trust, hope and belonging were fostered. These findings have implications for clinical practice in particular and more generally for all agencies who encounter women in these circumstances. The key findings of this research and their implications for counselling psychology will now be discussed before considering research limitations and future research needs.

5.6 Reflection on research process

Reflecting on the development of this research process and the personal insights that my experience may have brought will be reflected on here. Firstly, the interview questions were designed to draw out the paths navigated by women involved with child protection services due to their substance abuse problems and these were constructed from personal insight but also needing to be grounded in a literature gap.

Research regarding the effectiveness of parental interventions for substance abuse was found to be scarce in the UK (Forrester, et al., 2008; Niccols, et al., 2012; Templeton, 2012) with Niccols, et al's (2012) calling for further research to better understand the parenting needs of women with substance abuse issues. I used this gap and personal insights to construct questions that would capture this journey from initiation to a place of resolution for the women to enable the telling of these experiences retrospectively and from a place of wellness. I wanted to gain their perspectives on the sources of resiliency they tapped into which enabled long-term change. This question was important due to the relentless desire to escape a long, uncomfortable, and alien reality by returning to familiar state of intoxication. In all cases, as with myself, this came through connecting with others at various points.

Limitations to the study could be found in the interview process where I could have explored the responses of the participants in more depth, this became apparent at the analysis stage where further follow-up questions could have been asked which I refrained from doing as I did not want to lead or impose myself on the natural flow of what was shared and may have been in part due to my inexperience.

Another aspect that could inform future research would involve a mapping out of the relational points or connection to others along these processes. This could be achieved through a timeline of connections and interactions that occur prior to the eventual connections made through social networks and mutual-aid supports to gain a trajectory of these pathways.

Chapter 6 Clinical Implications

The aim of this current study was to explore the experiences of women who had previous involvement with alcohol addiction and child protection services to successful outcome to add to the scarce UK literature relating to interventions for parents (Forrester, et al., 2008; Niccols, et al., 2012; Templeton, 2012). This research explored the experiences of mothers who had passed through both addiction services and the resultant child protection services due to their substance abuse problems and key findings will be discussed.

6.1 Individual support

The findings support the need for greater care for mothers involved with social services due to addiction problems to prevent their further decline. This support should be offered in conjunction to the mother where concerns exist for the welfare of their children as findings show a marginalisation of the mother and a holistic approach addressing the needs of all involved is rarely experienced. Counselling psychologists are rarely involved with this client group but there is scope for service development where psychological formulation and planning can be implemented when concerns are first raised to identify needs and plan individualised treatment pathways for mothers.

There is a key role for counselling psychologists to work with this client group, particularly in terms of traumatic backgrounds and poor attachments. Use of the Adult Attachment Interview (George, Kaplan, & Main, 1984; Main, Goldwyn, & Hesse,

2002) would provide understanding of attachment failures experienced, damaged caused and type of therapy needed to repair the damage if they are to be supported as families.

The Government guidance in 'Working together to Safeguard Children' (DfE, 2015) makes clear the range of early intervention services that should be in place to support families but should be available across a continuum of need as these escalate in severity. These include family support programmes, access to drug and alcohol services, and domestic violence services. The findings of this study suggest that many of the women did not experience support relating to their needs either before children were removed or in the aftermath. Many of the women were left feeling threatened, unsupported, and outside of a process that was there to protect children but not address the reasons that led to protection needs in the first place.

The findings show that the majority of the women experienced themselves as outsiders during social services involvement, where their needs were not acknowledged as they did not have a social or support worker allocated to them specifically. The experience of the women shares themes of anecdotal evidence descried by Broadhurst and Mason (2013):

> *"…evidence suggests that following the compulsory removal of children, the plight of birth mothers all too easily falls outside service provision, leaving women to make their own sense of the lifestyle and relationship circumstances that have led to compulsory child protection intervention." (p. 292)*

The impacts of not being supported in times of need/crisis were still evident and voiced during the interviews so these relational elements formed part of the data. One woman's anger was still present in her voice while another spoke in deflated tones while describing her disappointment with the lack of social service support. These emotions show the real needs of women being marginalised and not being met by social services or referred on to those who could provide the right support. Considering the climate of austerity and the challenges faced by frontline services with decreasing budgets, research shows that more affluent LAs are able to provide higher rates of child intervention compared to neighbourhoods of deprivation (Bywaters, et al. 2018). This means services have fewer resources to help mothers and the focus increasingly has to be on the child in a service that has consistently failed to address the abusive backgrounds or socio-economic disadvantage of women pre and post-removal of children (Blanch, Nicholson, & Purcell, 1994; Schofield & Ward, 2011).

Key findings point to a severing of parent and child needs, even when children remain in the home, or later returned, without the original concerns being addressed, increasing mothers' feelings of desperation. All of the women in this study find their way to long-term abstinence, showing the potential for real change, but this rarely comes as the result of social service intervening showing a need to incorporate what truly works for these mothers at an earlier point. The 'Listening to troubled families' report (Casey, 2012) suggests attempting to fix a single issue is destined to fail if a wider view is not taken. All of the women in this research had varying degrees of trauma, including childhood sexual abuse, which rarely came to light during their involvement with social services even where there were repeat adoptions.

Goodman and Trowler's (2012) 'Reclaiming Social Work' model was introduced to rebalance the risk averse and bureaucratic approach by advocating clinical practitioners to work with the family and offering clinical interventions. Considering the findings of this study, where women felt threatened, confused, and unsupported by services, conversely these featured in their identified processes of change. An inclusive approach that offers support that reaches the depths of their pains needs to be provided through a multi-disciplinary approach where the needs and protection of children includes therapeutic support for the mother.

Recommendations to address the service deficits identified by the women in this study could be achieved through service and policy development where counselling psychologists can assess the needs of the women through psychological formulations that identify and inform treatment needs. These needs may be addressed through psychologically informed environments that can provide trauma based CBT, eye movement desensitisation and reprocessing (EMDR), Triple-P parenting programmes, and facilitated peer support or buddying systems that enable the women to strengthen their social supports.

6.1.1 Addiction services falling short

Important findings from this research indicate many of the women found the addiction services difficult. This is of concern considering the women also felt unsupported by social services. In both cases communication was a factor where they either felt they were on the outside of hostile processes or in the case of addiction services they experienced a sense of not being heard or services that were unable to meet their

desired goal of abstinence. The facilities in which services were offered also held some concern as those striving for abstinence having to contend with an environment that was not conducive to this goal.

Covington (2008) developed a treatment model that attends to the interrelationship between trauma and substance abuse in women's lives that provides a multifaceted approach. The Women's Integrated Treatment (WIT) model is based on three foundational theories, Relational-Cultural Theory (RCT) (Jordon, et al., 1991); a holistic theory of addiction based on a Behavioural Health Recovery Management (BHRM) approach (Boyle, White, Corringan, & Loveland, 2005); and trauma theory based on trauma-informed services (Harris & Fallot, 2001) and the three-stage model of trauma recovery (Herman, 1997; 1992).

The WIT treatment model devised by Covington (2008) has the capacity to provide a holistic understanding of the complex backgrounds of mothers who are subject to child care proceedings due to substance abuse. As mentioned above, trying to address single issues such as substance abuse in isolation is destined to fail (Casey, 2012).

The WIT model has the capacity to address many of the issues raised in this research and by previous studies (Broadhurst et al., 2017; Cawson, 2002; Cleaver et al., 1999; Ghaffar et al., 2012; Harbin & Murphy, 2000; Humphreys & Stanley, 2006; Kroll & Taylor, 2003; Statham, Candappa, Simon & Owen, 2002; Velleman & Orford, 2001) where trauma, domestic abuse, mental ill health and addiction form the back drop in the lives of women involved in child protection cases.

As discussed in section 2.5.4, the use of mutual empathy in RCT serves to aid the change process by reworking a person's connections and disconnections in therapy (Jordan, 2000). The use of RCT combined with Herman's (1997; 1992) three-stage model of trauma recovery provides a holistic therapeutic approach to the trauma Herman describes as the disease of disconnect. The three-stage model of trauma recovery, contained within the WIT model, firstly considers the woman's primary need to feel safe (physically and emotionally) which includes consideration of the environment in which treatment takes place.

This research study identified environments in which services were offered did not feel safe to the women in the theme speaking a different language. Services need to consider the needs of all services users, particularly women, who may have experienced abusive adult relationships and childhoods. One environmental finding from this research was the difficulty women can feel in an addiction service when they are striving for change yet others in the group are visibly still using. It is recommended that addiction services should provide a safe and therapeutic space for those who are truly striving for change evidenced by their desire for abstinence and the emergence of trust, honesty, and openness. Herman (1997) recommends twelve-step groups such as Alcoholics Anonymous as appropriate for stage one (safety) where a focus on present-tense issues and self-care can be addressed in a safe and structured environment. The women in this research echoed this, as they encountered mutuality, trust, and a capacity to be honest fostered through a sense of belonging when entering AA.

Outcomes are promising for the WIT programme, using the *Helping Women Recover* (HWR) programme (Covington, 2008; 1999), and *Beyond Trauma* (BT) (Covington, 2003). Women in a residential setting with their children found a significant decrease in both depression and trauma symptoms at the completion of HWR ($p < .05$) and further improvement ($p < .05$) when the women participated in the BT groups.

Further findings in this study involved the therapeutic alliance within addiction services and the women's ability to be honest with their support worker. Fear of honesty was experienced, due to the possible consequences of difficulties being communicated back to social services, preventing one woman from disclosing her true feelings. However, another woman found her honesty meant she could be truthful about her present circumstances and how awful she felt but this was beneficial to her progress.

Goodman and Trowler's (2012) *Reclaiming Social Work* model has capacity for counselling psychologists to be involved where work with parents and children can run concurrently providing support to the family as a whole. Counselling psychologists within the social work team are able to offer the WIT programme which provides the needed therapeutic alliance. The combination of RCT (Jordon, 2000) advocates healing in connection and the HWR (Covington, 2008; 1999) and BT (Covington, 2003) also acknowledges trauma and considers the environments in which services are provided. There is also acknowledgement of mutual support groups such as Alcoholics Anonymous and the benefits this can bring to those with substance abuse problems.

6.1.2 Change comes through mutual connection with others

A strong finding of this study was a lack of support in accessing services for substance abuse. The women often accessed services following a suicide attempt, or through their own chance encounters, rather than through the professional services directly. These findings, and those of wider literature, indicate that support for mothers to address their needs is not routinely offered (Slettebø, 2013). This leaves women in desperate states, managing their addictions, the threat of or removal of children, feelings of shame, stigma, and untreated trauma symptoms, yet all of the women in this study managed to achieve long term abstinence from their substance use, demonstrating resiliency.

Resiliency is a well-researched phenomenon, and has been defined as an ability to adapt well when faced with trauma or adversity (Alim, et al., 2008; Collishaw et al., 2007; Feder et al., 2009). It could be argued that the women in this study did not show resiliency, as people are deemed resilient if problems do not develop (according to Garmezy, Masten, & Tellegen, 1984), whereas an increase in substance abuse and mental health problems were reported in this study. Another definition of resiliency describes *"a dynamic process that is influenced by both neural and psychosocial self-organisations, as well as the transaction between the ecological context and the developing organism"* (Curtis & Cicchetti, 2007, p.811). Further description by Masten (2001) suggests that when considered as an outcome, resiliency is *"a class of phenomena characterised by good outcomes in spite of serious threats to adaptation or development"* (p. 228). Both of these descriptions fit

the findings of this study and what the women describe as aspects fundamental to their change process.

In the context of identified aspects of resiliency, participants, describe a dynamic process of change in relation to another person, usually of similarity. The reorganisation of self on a psychological level and effects of the psychosocial environment as defined by Curtis and Cicchetti (2007) can be seen in these findings. Descriptions of resiliency are defined as internal changes where distorted and untamed characteristics are reworked to their useful size and purpose, thoughts of defectiveness are changed, and honest self-appraisals take place where consideration of positive self-aspects are given space to be realised. These processes of change all occur in connection to others where safety and trust is developed. It can be argued that all of the women in this study meet Masten's (2001) criteria for resiliency, where good outcomes are reached despite serious threat to development and a poor adaptation to life events.

Finding purpose in life emerged as a key psychosocial factor associated with trauma recovery and resiliency in Alim et al's (2008) study, a finding that fits with existential theorists, such as Victor Frankl (1967) where meaning and purpose influence a person's ability to manage stressful life experiences. A quote by Leontjev (1977) resonates with the difficult paths these women trod but when shown and led by example of others what may lay ahead if they continued on their journey, change became possible,

> *"I once heard an old horseman on Ural tell me that when a horse starts to sweat on a difficult road, it should not be beaten, but its head should be lifted so that it can see further ahead"* (p. 178).

Frankl (1967) describes a change in attitude toward an unalterable fate, it can be argued that the findings of this study show psychological movement in the minds of the women. There is an acceptance of their inability to safely consume alcohol and the suffering it creates through their honest self-appraisals. This is not a journey they take alone but one that is guided in the mutual companionship of others who lift their heads to see further ahead by leading through example.

Counselling psychologists have much to offer this client group considering their training in lifespan development and grounding in humanistic approaches where the therapeutic alliance is central to practice, allowing the other to be heard and valued in a mutual therapeutic environment that the women found to be key in their change process. Counselling psychologists are trained to provide therapeutic frameworks and programmes such as Goodman and Trowler's (2012) *Reclaiming Social Work* model and WIT model (Covington, 2008) that facilitate the actualisation tendency through the provision of the core conditions within the person-centred therapy framework (Rogers, 1961; 1963b).

6.1.3 Conclusion

The current study showed that the backgrounds, and lives of mothers with substance abuse problems are complex and the following conclusions are drawn. Most women

who encounter child protection services are likely to have addiction problems but receive little support for this problem. For many women, help only becomes available as they reach the psychological depths of despair and/or suicide attempts. The provision of help is ineffective and unable to facilitate abstinence based programmes. As the majority of women in this study have had childhood traumatic experiences and suffered from domestic abuse, it may be that most women who encounter child protection services possess these life characteristics. Trauma and the lasting effects of domestic abuse were not addressed by services, as the women attempt to relinquish their anaesthetics, leaving some of these women at greater psychological risk and in a position which is bound to fail.

The findings from this study have implications for the role of counselling psychologists in the areas of child protection and addiction services. Counselling psychologists are in a unique position through their training and clinical experience to provide therapeutic environments that meets the real needs of these women. The application of scientific knowledge to therapeutic practice as described by Strawbridge and Woolfe (2003), and guidelines for counselling psychologists to develop research and practice which is grounded in the therapeutic relationship (DCoP, 2005), has much scope for this client group. Counselling psychologists are trained and able to formulate systemically, meaning they can consider the influence of social and cultural issues for each individual. Considering the presence of mental health needs in this client group and untreated trauma, addiction and mental health interventions could be addressed through policy and service provision that accommodates the dual-needs of women when initial referrals are made.

6.1.4 Original Contribution

An original contribution of this study is the healing which occurs, for all of these women in relation to others. Psychological connection is paramount and can be achieved through the therapeutic alliance. These connections provide a place of psychological healing, to readdress the lasting effects of trauma, abuse, stigma and shame. The Relational-Cultural Theory, where healing occurs in connection, and the provision of trauma based work contained in the gender specific Women in Treatment programme is something counselling psychologists can bring to the field of child protection in the UK. This can be achieved by raising awareness of these therapeutic approaches, through training programmes and CPD that would enable the valuable contributions that Counselling Psychology has to offer, accessible to social work departments.

6.2 Study limitations

The findings presented here are just one possible construction and represent my interpretation of the data. Considering my own personal experiences of the research subject, every effort was taken to distance my own biases by being open to the experiences of others and journaling to bracket my own countertransference. Others may have interpreted and found other themes more salient, however, every effort to produce rigorous analysis was made by remaining close to methodological guidance. IPA and RCA are limited and do not make generalisability claims, the findings do however, contribute to the knowledge base of the experiences of mothers with

substance abuse problems in the UK giving, a needed voice and understanding of the life world of mothers who lived with and survived substance abuse problems.

6.3 Future research

Important areas for future research emerged from this study. Firstly, it would be interesting to explore the parallels between the theme ‘No place for you’ where women feel rejected, blamed, excluded and alone in the context of social services and their personal life experiences of feeling marginalised. Considering the traumatic adult and childhood relationships of many of the women in this research, and wider research (Broadhurst et al. 2017), there is a re-traumatising effect for women from services themselves. The impacts of this and how it impinges on their capacity to engage with services may provide valuable insights not only for change in service approach but also for the therapeutic needs of these women.

Another important finding in this research was the language used by addiction services and the impact this had on women’s engagement with services. Broadhurst et al.’s (2017) study highlighted service non-engagement as an area of great concern raised by the local authority at index and repeat court proceedings for 354 mothers. Language of alcohol control, and unit measurement through the use of drinking diaries left some women in this study in a position needing to lie to fit the service treatment model or the severity of their problem not being acknowledged, this is an important consideration that affects service engagement. Complete honesty was found to be invaluable to the recovery process of the women in this research, yet experiencing services that they felt unable to be honest with, is an area requiring

further research due to the possible consequences to these women and their children.

Considering the lack of referral to organisations such as AA when it has been shown to be the key factor in the change process for the women in this research raises questions as to why this valuable and free resource is not advocated more by the medical profession, social services and addiction services here in the UK.

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Appendix A - Ethical Approval

Re: Minor Amendments to Study

Date 22.06.16

Gail Freedman (Angela Morgan)
University of Wolverhampton
Faculty of Education, Health & Wellbeing

Dear Gail Freedman (Angela Morgan)
Re: The lived experience of mothers who have navigated alcohol addiction and child protection services in England submitted to The Faculty of Education, Health and Wellbeing Ethics Panel (Health Professions, Psychology, Social Work & Social Care)

The Faculty Ethics Panel (Health Professions, Psychology, Social Work & Social Care) has considered and reviewed your proposed minor amendments**.**

On review your Revised Research Proposal was passed with the following comments.

It is not just about adding Facebook as a recruitment measure it is all the other implications that this entails which we have not received information about. The approval is on the assumption that the supervisor will make sure the necessary changes are in place and is happy as to how participants will be accessed and later interviewed (a particular example is they would require a different information sheet [not given here] which says they have been chosen as they replied to Facebook).

The Panel believes that the ethical issues inherent in your study remain adequately considered and addressed. Therefore, the Panel accept your amendment (**Code 1 - Approved**). We would like to wish you every success with the project.
Yours sincerely

H Paniagua
Dr. H. Paniagua PhD, MSc, BSc (Hons) Cert. Ed. RN RM
Chair – Ethics Panel

Richard Darby
Dr Richard Darby PhD, BSc
Chair – Ethics Panel

Appendix B – Facebook Message

Dear Group, I hope you don't mind me sharing this here?

I am in recovery myself and have been through these experiences.

I am embarking on a PhD at the University of Wolverhampton, researching the "lived experience of mothers who have had contact with both child protection and alcohol services", in order to understand more about treatment and support needs.

If you have been through these processes and are willing to take part in a confidential interview or want to ask any questions about this study please contact me at: g.freedman@wlv.ac.uk or private message.

Appendix C - Semi-Structured Interview Schedule

Hello, my name, is Gail Freedman and I am a Counselling Psychology student, I am doing research into the experiences of mothers that have had contact with child protection and alcohol addiction services to find out first-hand how this was experienced by you. I am hoping that the outcome of this study will help to inform the services on what works and what does not work from the perspective of the mother herself by ensuring your voice is heard.

Thank you for agreeing to take part in this interview. You are aware that every effort will be made to ensure your anonymity and the protection of anything you say during this interview. I must remind you that this has limits if you were to say anything that raised concern for the well-being of yourself, others and in particular any children then the interview would need to be stopped and the information shared with the relevant agencies.

Demographic Details

Date of Interview

Participant ID

Age

Number of year's problem lasted

Time since problem has been resolved

Contextual Mapping: Experience of Social Services and

Question: 1 Please will you help me understand what events in your life led up to you being involved with child protection services?

Prompt 1: How did they become aware of your situation?

Prompt 2: How was the first contact made and by whom?

Question: 2 Can we now talk about the variety of different addiction treatment services you have had contact with?

Prompt 1: Who put you in touch with these services?

Prompt 2: Thinking about the treatment they offered, does anything they did for you stand out in your mind? (Positive & negative).

Access to Resources and Support

Question: 3 When child protection services became involved in your life what resources and support was offered and by whom? This could be either something that was self-initiated or mandated by the agencies involved.

Prompt 1: What stands out most about the help you received?

Prompt 2: Can you tell me how this was or was not helpful?

Prompt 3: Did you have to wait for treatment, if so, how did you manage while you were waiting?

Question: 4 Thinking specifically about the addiction services you have been involved with; can you tell me about the resources and support they offered?

Prompt 1: Did you receive any counselling, therapy/, and/or group work?

Prompt 2: What did you found most useful and why?

Prompt 3: Were there aspects of the support that were unhelpful or made your situation more difficult

Resilience in Adversity

Question: 5 Looking back from where you are now, what have you noticed about yourself that helped you during the difficult times in your journey?

Prompt 1: How did you manage when things seemed difficult?

Prompt 2: Did you draw on any support systems?

Prompt 3: What were the sources of adversity?

Prompt 4: What were the sources of resilience?

Again, can I thank you for your willingness to share with me this personal experience, it has been very enlightening and informative.

If you have any questions please do not hesitate to contact me on the details provided.

Appendix D – Consent Form

Title of Project: The experiences of women who have successfully navigated child protection and alcohol addiction services

Name of Researcher: Gail Freedman

Please initial boxes

1. I confirm that I have read and understand the information sheet dated 12th December 2015 for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up to final submission of the research without giving any reason. ☐

3. I understand that my data will be stored securely and confidentially and that I will not be identifiable in any report or publication unless I wish to. ☐

4. I understand that the researcher may wish to publish this study and any results found, for which I give my permission. ☐

5. I agree for my interview to be tape recorded and for the data to be used for the purpose of this study. ☐

6. I agree to take part in the above study. ☐

……..	……..	……
Name	Date	Signature
……..	……..	……
Name of person taking consent (if different from researcher, state position)	Date	Signature
…….	…….	……
Researcher	Date	Signature

Appendix E – Information Sheet

12th December 2015

INFORMATION SHEET

The lived experience of mothers that have had contact with child protection and alcohol addiction services

Gail Freedman

Trainee Counselling Psychologist

g.freedman@wlv.ac.uk

You are being invited to take part in a research study. Before you decide whether or not you want to participate it is important to know why the research is being done and what it will involve. Please read the following information carefully and please email me if anything is not clear or further information is needed before a decision is made.

What is the purpose of this study?

Research regarding the effectiveness of parental interventions for substance abuse is scarce in the UK, and research to better understand the experiences of women who have been through the process of child protection services and addiction services successfully is important to help improve services. Successful in this case means women who are no longer involved with social services or being monitored for alcohol use. They may be involved with self-help or support groups for addiction/alcohol problems but this would be of your own choice rather than anything that was part of previous care plans.

This will enhance the understanding of how these services worked or did not work and were experienced from the women's perspective through interview.

Why have I been chosen?

It is completely up to you whether or not you take part in this research interview. However, if you do decide to share your experience through confidential interview, you are still free to withdraw your data without consequence, up to the point of final submission of the research.

If you are currently involved with any on-going treatment/therapy this will in no way be affected by withdrawal from this study.

Do I have to take part?

It is completely up to you whether or not you take part in this research interview. However, if you do decide to share your experience through confidential interview, you are still free to withdraw your data without consequence, up to the point of final submission of the research.

If you are currently involved with any ongoing treatment/therapy this will in no way be affected by withdrawal from this study.

What will happen if I decide to take part?

If you do decide to take part, you will be invited to meet with the researcher, at a time and place that is convenient for you. You will then be asked to take part in a semi-structured interview. This would be audio recorded on a password-protected Dictaphone that means it cannot be accessed by anyone else apart from the researcher.

This would be a one-off interview that would then be analysed by the researcher to understand your lived experience of the time of involvement. The questions would be concerning access to treatment for substance use, how these were experienced, how referral came about, how long did you have to wait, were they helpful, did you have one-to-one support or group work, did you have access to counselling/therapy – if so was it helpful? And any other comments about your experience during this time.

This research would not be completed until July 2017 where a brief outcome from this could be shared with you if you wish.

What are the potential benefits and risks of taking part?

There is no direct benefit to you for taking part in this study, but the sharing of your experience may add to the understanding of how these processes are experienced, as well as what does/not help. This information may help inform future practice and ways of improving service provision.

Potential risks to you may include recalling an upsetting time in your life that may feel distressing. If this happens, you are free to withdraw there and then or refrain from answering specific questions you find distressing.

Will my taking part in the study be kept confidential?

Interviews will be anonymised, that is your name, location, and any other identifying information will be changed to protect your identity – unless you state otherwise. The recording will be on a password-protected Dictaphone, and transcribed interviews will be stored in a locked cabinet for 3 years and then destroyed. Access to this will be limited to the researcher and the two supervisors working on this research.

Confidentiality will be respected and maintained throughout the research process, the only exception to this would be if safeguarding issues were raised. This would be any information during the interview that indicated that you or someone else was at risk of harm. This concern could then to be taken further. This would involve the researcher contacting the research supervisors regarding any harm to you or anyone else. Research supervisors in this case means those who are more experienced and who have been appointed to oversee the study and who would advise the researcher on the necessary steps that need to be followed.

What will happen at the end of the research study?

The findings of this study might be published in a learned journal or presented at conferences so that relevant people can understand further the experiences of mothers during this period of time. If this

were to happen, the anonymity status would still be maintained. You may contact the researcher or supervisors of this project for a summary of the findings. These will be available by July 2017.

What if I have a problem or concern?

If you have any concerns or questions about this study please contact the researcher or supervisors of this project on the emails provided below who will be happy to answer any questions you have.

Researcher – Gail Freedman - g.feedman@wlv.ac.uk

1st Supervisor – Angela Morgan - angela-morgan@wlv.ac.uk

2nd Supervisor – Abigail Taiwo – a.taiwo@wlv.ac.uk

Who has reviewed the study?

The Research Ethics Committee in the Faculty of Education, Health and Wellbeing of the University of Wolverhampton has reviewed (and approved) this study.

Contact for further information

If you have any questions or would like further information about this research, please contact me on the above researcher email address.

Appendix F - List of resources for external support

Changing Lives Women's Centre

Claverley Drive,

Wolverhampton

WV4 4QL

Contact Tel: 01902 341822

Email: Sukhi.Sian-Claire@changing-lives.org.uk

Service Description: Working with women throughout Wolverhampton offering counselling, confidence courses, training courses and social drop ins for women. (Access: Self-referral)

Wolverhampton Healthy Minds:

Black Country Partnership Foundation Trust Cleveland House,

West Park Hospital, 10-12 Tettenhall Road,

Wolverhampton,

WV1 4SA

Contact Tel: 01902 441859 or 01902 441594 Email:

wolverhamptonhealthyminds@bcpft.nhs.uk

Service Description: Wolverhampton Healthy Minds is a psychological therapies service for people who are experiencing common mental health problems such as depression, anxiety and stress. Access: G.P. who will give a letter or referral "ticket" with details of how to contact the service.

Samaritans

54 Newhampton Rd West,

Wolverhampton

WV2 6RU

Contact Tel: 08457 909090

Service Description: Suicide Prevention.

Wolverhampton Substance Misuse Service Head Office:

Horizon House,

Pitt Street,

Wolverhampton

WV3 0NF.

Contact Tel: 0300-123-3360 (Lines are open 24/7) Fax: 01902 427 300.

Email: talktous@recoverynearyou.org.uk,

Website: www.recoverynearyou.org.uk/wolverhampton360

Service description: Wolverhampton Substance Misuse Service is a confidential service for the people of the city. We help anyone who is concerned about their own drinking or drug use or someone else's. Monday-Friday 9.00-17.00 hrs Access: Individuals can refer themselves or by their families/friends and also from GPs, police, probation and any professionals.

Appendix G - Participant debriefing sheet

Thank you for participating in this study. The aim of this research is to gain further understanding of the experiences of women who have had contact with social services and alcohol addiction services and resolved their substance abuse problem to enhance understanding of the treatment and support needs of women.

You can contact the researcher via email g.freedman@wlv.ac.uk if you would like to be provided with a summary of the findings. These will be available to you in July 2017.

If you have any further questions in relation to this study please do contact the researcher on the email above.

Thank you

Gail Freedman

Trainee Counselling Psychologist

Appendix H - Transcription convention meanings

Symbol	Meaning
“ “	Quotation marks indicating beginning and ending of quote
‘ ‘	Quotation marks indicating a quote within a quote
(omitted/changed)	text omitted or changed to preserve anonymity and confidentiality
[added]	word/s added for readability
(non-verbal or emphasis)	Non-verbal gestures or emphasis in speech tone
…	Pauses and silences

Appendix I - Participant theme tables

Theme Table Kim

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"I went to my G.P. for some help 'cause I didn't know where to turn to, I couldn't cope with the children, I couldn't cope with what was going on within me" (Kim, 44-46).*
	Overwhelmed & needing support	*"I wanted some support, some help, erm you know to get over the rel…ationships I'd been in (in-breath) and start healing I suppose but at that time I didn't know the best way to go, go forward, but social services did seem like the only way forward at the time" (Kim, 56-60).*
	Instability draws attention	*"I didn't pick the children up, I wasn't there when they came home from school, erm I'd gone to town, all good intentions to buy some coats, to buy some winter coats for the two boys and ended up spending that money on drink and drugs" (Kim, 88-90).*
	Harsh reality	*"Social services phoned me and told me not to go near my two children…if I wanted to go to court that day I could but there would not be a magistrate in this country that would give me custody of the children. Erm so from then they were taken into protective services" (Kim, 97-100).*

	Harsh reality	*"So yeah, from then on there was absolutely no intervention with me, it was just point blank (harsh voice) 'we're not interested in you, you can go off and do whatever you want you know it's all about the children'" (Kim, 122-124).*
No place for you	It's not about you	*"I was living with an alcoholic having an alcoholic's baby, do you know what I mean, there was just no, you know (deflated tone) there was just* [I] *felt pretty let down by them and they categorically said they weren't there for me they were there for the children's sake" (Kim, 527-530).*
	It's not about you	*"A bit of childcare but there was nothing on the practical side of you know, me giving up the drink and drugs, you know that was left to me to deal with" (Kim, 423-424).*
	Sense of aloneness	*"I didn't have a key worker, I didn't have a social worker working with me it was just about the children and that was quite damaging the way the children were brought back to me and yet there was no work done on me" (Kim, 520-522).*
	Falling apart	*"And they did eventually come back to me after about eighteen months. Which wasn't* [a good idea] *'cause I was into relating the time my children*

		weren't with me, I got into another violent relationship, another drinking relationship, drugging relationship" (Kim, 129-132).
Change as a psychological journey	Speaking a different language	*"Obviously when things were on the up and I didn't need so much intervention and I didn't need to see my key worker and this is after a couple of years, you know that's when I fell through the loop again and erm I picked up" (Kim, 487-489).*
	Letting down the barriers	*"We would have group therapy and talk about our addictions…and I didn't feel as isolated. The first time round I felt isolated on my own, that's why I never got my life together you know 'cause I was on my own, my kids were removed and I'm all on my own" (Kim, 445-448).*
Trauma & transformation	Abusive cycles	*"Which wasn't the best set-up because my grandfather had molested me as a child so I told social services what the risks were you know" (Kim, 106-107).*
	Abusive cycles	*"I was erm prostituting and I had a pimp, and I had a drug, amphetamine problem and alcohol problem and things got really risky and dangerous. The relationship was very violent, erm I managed to get out of that relationship" (Kim, 36-39).*
	Changing through	*"I've always been knocking at doors and thinking I was mad or there was something terribly wrong*

	connection & hope	*with me and I think when I walked through the doors of AA Alcoholics Anonymous I kind of got that connection again and that hope" (Kim, 674-677).*
	Changing through connection & hope	*"I just knew she was going to some kind of meetings to help with alcohol problems and erm she asked me if I could get to a meeting and gave me the times and venues where they were. I got myself to the next one which was on a Friday morning and I've been going ever since (laughs)" (Kim, 699-702).*

Theme Table Nicola

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"I just had this child, I felt I wanted to escape him, erm and then I started drinkin…I suppose as the years went on and I started drinkin more, erm the anxiety and the alcohol together, I started to turn up at the doctor's and say I was depressed or I was feeling anxious" (Nicola, 43-47).*
	Instability draws attention	*"They said they would have to tell social services that you know I was a parent and I was drinkin, but it was the alcohol service" (Nicola, 82-84).*
	Harsh reality	*"They didn't understand it and I think their way of trying to help people be sober was I felt quite threatened and you know if you drink again we're going to take your daughter away" (Nicola, 256-260).*
No place for you	Sense of aloneness	*"As soon as I left there I started drinking straight away even though I had pretty much six months of sobriety…When I left there I just kind of felt lost again which is really weird but it was difficult not being there anymore" (Nicola, 221-225).*
Change as a psychological journey	Speaking a different language	*"I had to engage with the services you know and it wasn't always easy, sometimes I'd be in groups where people were active you know, they were dinking in the break, they'd drink on their way in and when you're trying to be abstinent it wasn't very*

		helpful" (Nicola, 265-269).
	Speaking a different language	*"I didn't really get the sense she was really listening to me so I didn't feel like being honest with her. So, I was just like 'I'm great' I'd walk in like 'I'm great yeah, I'm not drinking.'" (Nicola, 401-404).*
	Letting down the barriers	*"We appreciate you being honest with us, so even though my life was still a mess and I felt really crap about everything I still get that well you're doing something good 'cause you're being honest and that's something I found really difficult to do, be honest" (Nicola, 570-574).*
Trauma & transformation	Abusive cycles	*"I wanted to die but even though I was really selfish I just thought you can't do it to them (voice softens) it's not their fault, to my children and family. I thought we'd seen two suicides in my family, one of them was an alcoholic, threw himself under a train and the other hung himself. My uncle and my son's grandfather within six months of each other so I've seen the pain and devastation caused by that" (Nicola, 481-487).*
	Changing through connection & hope	*"There had to have been a little of hope somewhere because in all the times of engaging in the services and going to all the recovery groups I could see people who were not drinking and going to 12-step meetings" (Nicola, 461-464).*
	Changing through	*"Progressing in their lives and there was never going*

	connection & hope	*to be any progression in any area of my life, not my mental state, I was never going to get a better job, I was never going to get anything I wanted, I was never going to be able to be in a relationship" (Nicola, 469-473).*

Theme table Jane

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"Err, when we split up I continued drinking to help me sleep and don't know it's like I just crossed that line where I was drinking 24/7" (Jane, 40-41).*
	Instability draws attention	*"When my son was six months old I picked up, erm which was just the one, which I thought was just the one drink, err I dropped my son off at nursery and I don't remember much but that's when they became involved" (Jane, 74-76).*
	Harsh reality	*"They came round and she the lady came round with a police officer (raised and surprised voice) err saying 'that my son was took away, that they were gonna get him adopted out, he was at that age he could be adopted" (Jane, 102-105).*
	Harsh reality	*"So literally the were telling me (anger-raised voice) no support whatsoever, literally they were just saying 'you're a drunk, were gonna take your son off you, get him adopted out, he's at that age, your family are fed up with you'…no support no nothing, no nothing" (Jane, 108-111).*
No place for you	It's not about you	*"I'm being completely honest you know before I used to go to the case conference I'd still have a drink, erm so really I was doing everything wrong (voice breaks)*

		but they weren't, I wasn't getting that support, what I know now and what I knew then, I felt alone, trapped and no one understood me" (Jane, 196-200).
	Sense of aloneness	*"My G.P. was really good with me but her kept throwin diazies* [diazepam] *at me, you know do it yourself. (voice raises) You know at no point did anyone say to me there's a treatment centre…I was so desperate if they'd have offered it me I'd have done it but in the end, I had to do it myself" (Jane, 473-477).*
	Falling apart	*"I didn't go to case conferences but at this stage I was well into drinking and taking other substances. So, for six months I was in and out of blackout, erm, I never attended the case conferences" (Jane, 228-231).*
Change as a psychological journey	Speaking a different language	*"I went to* (Alcohol service) *where they said I could probably reduce with a drink diary and I told them that was not possible, I had to be completely abstinent" (Jane, 164-166).*
	Speaking a different language	*"I had a support worker who literally, looking back at it, I used to lie to her, she'd say 'how are you feeling?' 'I feel great (smiles).' I didn't feel great you know. 'Have you had a drink? You know you are allowed*

		three units.' Yeah I've had three.' Three bottles (raised voice) everything was a lie, I was lying to myself you know erm and I was still drinking" (Jane, 188-192).
	Letting down the barriers	*"I was scared to tell* (addiction service) *how I really felt in case they told social services but now I've got a phone full of people I can ring and say…'I'm having a bad day' and they're like 'ok, I'll be there in half hour' (clicks fingers). Let's go to a meeting, let's go and have a coffee, straight away I feel better" (Jane, 643-646).*
Trauma & transformation	Abusive cycles	*"I was admitted to hospital several times…I tried to commit suicide several times, all I remember is coming around in a hostel…thinking I was sober, I was in withdrawal thinking where am I, where's my children, where's my mom" (Jane, 242-245).*
	Changing through connection & hope	*"With the support of my support worker at the hostel…luckily for me he was on a 12-step programme…so he knew about addiction…he gave me all the information of the meetings in* (location) *and erm I started going to church, I went to my first meeting and got to know a few of the ladies" (Jane, 302-306).*
	Changing through connection &	*"I do feel I put the drink before my children (hushed voice) before anything but that's all I'd got and the*

	hope	*more pressure social services were putting on me the more I drank. If they'd had the knowledge to put me on a programme it would have stopped a long time ago" (Jane, 521-524).*

Theme table Kayla

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"…They said I suffered from postnatal depression, erm they stayed watching but because I was doing everything a mother should do they weren't really worried because I was on antidepressants" (Kayla, 55-57).*
	Harsh reality	*"She went to the fridge and got the cider out, got a flannel and put it on my head and that was the last straw. I thought nope, I'm not doing this to her, she deserves better…I phoned up social services and I said, 'you need to take my daughter'" (Kayla, 68-73).*
	Harsh reality	*"They didn't give me a chance, they said 'no we're taking you son off you' so I just went* ***what for*** *kind of on the drink and drugs, it was kind of like I don't care, I've lost everything and I just went on a major binge and disappeared (laughs) from social services" (Kayla, 85-88).*
No place for you	It's not about you	*"They didn't even let me go to them, they didn't tell me about them or anything. They just went bam! There you go, taking your son off you, job done" (Kayla, 488-490).*
	Sense of aloneness	*"Erm, the only support I had was my birth mom but she was not very supportive because she is*

		an alcoholic and an addict" (Kayla, 458-459).
	Falling apart	*"I went back on the drink full force 'cause I couldn't cope with it, sent me doolally" (Kayla, 482-483).*
Change as a psychological journey	Speaking a different language	*"Telling you, you can control your drinking, you can't if you're an alcoholic or an addict. You can't control your using or your drinking, it's just that you are powerless over the stuff, that's why you want help" (Kayla, 761-763).*
	Letting down the barriers	*"Just getting honest and I've been completely honest with my sponsor, she knows everything (emphasis) and I mean everything" (Kayla, 835-837).*

Trauma & transformation	Abusive cycles	*"I thought there's no such thing as love, I thought if you love someone then why would you do that. Erm, then it's cause my parents didn't do anything about it, I got annoyed with them, I hated them for it. So, I had a lot of hate, lot of fear, lot of anger and it just came out side wards" (Kayla, 94-945).*
		"Yeah, sexual, physical and emotional, the whole package" (Kayla, 957).

		"It was my brother" (Kayla, 961).
	Changing through connection & hope	*"I surrendered and eventually got to AA, I was watching other people's behaviours and how they acted and how they spoke and I thought I want to be like that, I'd love to be like that" (Kayla, 831-834).*
	Changing through connection & hope	*"It's helped me learn who I am as a person, not all the defects and nattiness that I thought was. I now know that I'm a loving, caring, kind, considerate woman who went through a lot of shit (apologises and corrects self) rubbish" (Kayla, 841-845).*

Theme table Cara

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"I had my first child in* (year), *I was living in you know quite an isolated place and I was drinking a lot. Urm, the drinking escalated and my anxiety levels were really, really high. Urm, I think it got worse after having the baby. I informed the health services of how I was feeling" (Cara, 108-112).*
	Instability draws attention	*"I was just (phew) very broken it was awful, the police, every night there was some chaos, some drama and it all happened because it got worse. I would say it was like you know when you're spinning all these plates in the air and all of a sudden, they crash down. That's what happened" (Cara, 264-268).*
	Instability draws attention	*"The thing which I found quite strange was they didn't pick me up on it when I went to get him, they didn't say 'no you're not taking the child, you're drunk' they just let me go with the child and the phoned social services" (Cara, 160-164).*
	Harsh reality	*"What happened to being with was they phoned me up and said, 'we've had blah, blah, referrals about you, you just need supervised access' and that was it nobody came to see me, I was like what does that mean?" (Cara, 176-179).*

	Harsh reality	*"We didn't understand why they were put on the child register when they were with my partner…'cause they weren't in my care…and again it was unclear because they were saying 'aww…they can come and stay with you if you're ok'* [not drunk]*" (Cara, 209-214).*
No place for you	It's not about you	*"I asked my social worker, the kids social worker for help finding somewhere to live so when I was sober I could live with the children and she said, 'I'm not here for you I'm here for the children'" (Cara, 304-306).*
	Sense of aloneness	*"She treated me like I was nothing and I'd brought this all, maybe on myself, I just felt I didn't have any support" (Cara, 313-314).*
	Falling apart	"*You know the court and everything was unravelling, I'd done so well over the years keeping it a secret (laughs) and holding on and it all just you know was out in the open and you know to be honest it felt like a relief, it was out in the open and I thought I don't have to hide it, I can just drink now" (Cara, 665-669).*
Change as a psychological journey	Speaking a different language	*"In the detox centre, they do a relapse prevention but they say…which was like gold for me, was they tell you, you can have a lapse, there's a difference between a relapse and a lapse. A lapse it like 1-2 days and then that's in your head 'ding, ding' (bell sound.) Oh, so I can have a lapse then, that's fine" (Cara, 909-913).*

	Letting down the barriers Letting down the barriers	*"Rehab was the best you know 'cause as a result of that I've been sober nearly four years" (Cara, 725-726).* *"After step-five* [part of a 12-step programme] *wow I just felt amazing. I was in a room with someone who I trusted and I trusted them wholeheartedly and I did tell them everything, there was nothing I kept to myself and we were there for maybe five-six hours and that was a turning point for me as well I think" (Cara, 938-942).*
Trauma & transformation	Abusive cycles Changing through connection & hope	*"*[I] *wasn't trying to kill myself it was my head…I just wanted everything to stop' (Cara, 509-510).* *"I enjoyed learning about myself even though a lot of it was horrible but the peers were there with you, you know that was positive – the people going through the same thing and the people and counsellors had been through the same thing – so you couldn't like – I was arrogant and cocky so I couldn't say 'you don't know what I'm going through' (arrogant voice) 'cause they had" (Cara, 780-785).*

Theme table Jackie

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"There was a lot of chaos around it, and that for me is when I know that the insanity stepped in because I was drinking two nights a week, maybe three a week during pregnancy" (Jackie, 119-122).*
	Instability draws attention	*"On that fateful morning, my second son had picked something up and chucked it at me so I picked it up and chucked it back and it hit him so my daughter picked up the phone and told her dad. So (sarcastic voice) daddy phoned social services" (Jackie, 296-299).*
	Instability draws attention	*"Social services came later that night with child protection and I'd had a couple of drinks so basically they said, 'were taking the kids into care', so that's what brought it to a head" (Jackie, 300-303).*
No place for you	Sense of aloneness	*"You're just a number and when I came out of the mother and baby unit and came back here, everything they promised to put in place did not happen, out of sight out of mind" (Jackie, 574-576).*
	Falling apart	*"I can't tell you if it was a relief or what but there was a scream, I was screaming help and I reached out for help in the only way I knew, through chaos and alcohol, I knew I wasn't coping" (Jackie, 493-496).*

Change as a psychological journey	Speaking a different language	*"I'd got the addiction service saying I could probably learn to control it, 'cause they said, 'do you want to give up drinking?' I said, 'well no not really.' I was still in that blame, I didn't know I was an alcoholic, erm, they said I could probably learn to control it" (Jackie, 364-368).*
Trauma & transformation	Abusive cycles	*"I was in a marriage that was abusive and violent but looked fine on the surface. I very much recreated my childhood in adulthood where everything looked wonderful on the surface. There was no alcoholism is my childhood but there was violence" (Jackie, 62-66).*
	Changing through connection & hope	*"I'm one of the privileged ones that was given the survival instinct to bring this to the recovery process because people aren't meant to survive the system. And those patterns of mine, what they used to be, I'm still rebellious (laughs) I'll say it how it is, but those patterns, the 12-step programme has helped to mould and shape* [them]*, they're more soberly useful that I can be the person I was meant to be in the first place" (Jackie, 88-889).*

Theme table Gillian

Superordinate Theme	Subordinate Theme	Quote
World comes crashing down	Overwhelmed & needing support	*"…As I said previously my dad had passed away and my father had always been there for me regardless and erm I missed, even though he didn't know what to do he was a form of someone I could off load to" (Gillian, 179-182).*
	Instability draws attention	*"…My fear was about being caught with the drugs and no concern for the person's welfare…erm needless to say social services and police were called" (Gillian, 82-84).*
	Harsh reality	*"Needless to say, I was all over the place and devastated, I could not believe this was happening to me, my family at that time. Urm, my daughter said to me age ten, 'don't worry about me mommy, I'll be fine, I'll just look at it like I'm going on an adventure'" (Gillian, 122-125).*
	Harsh reality	*"The girls seemed to manage reasonably well and a lot better than my youngest son did, he became really withdrawn, wouldn't talk, wouldn't eat, erm the day they took him from school, erm he was screaming and crying and he kicked and bit the social worker, erm I was distraught because it was my son's birthday and he'd got a cake at home and everything and…" (slow pace) (Gillian, 154-159).*

	Harsh reality	*"Needless to say, when they were first taken it was a case of I'd just become more depressed, took more and more drugs and the only time I made any effort to do anything was when I had contact with the children" (Gillian, 280-283).*
No place for you	It's not about you	*"I don't feel that regarding social services that they, for my partner or myself that they gave, you know it was just like they came and they took the children. They said there'd be a court hearing, there was no back up" (Gillian, 254-257).*
	Sense of aloneness	*"My drinking and drugging spiralled more out of control after they were taken, it was just like there was nothing, there was nothing" (Gillian, 242-244).*
	Falling apart	*"The last three years was even worse you know with the kids being gone, they kept me you know, as much as I wasn't a mother to them, they kept me in some kind of, I wouldn't say I was consistent but some kind of consistency if that makes sense" (Gillian, 462-465).*
Change as a psychological journey	Letting down the barriers	*"Being more open…I'd still say I'm wary of people, I think it's natural to an extent. I am more of an open book today, I'm not ashamed of where I've come from, whereas I used to be ashamed" (Gillian, 719-722).*

Trauma & transformation	Abusive cycles	*"I was just doing the minimum as I could, just to hang on in there. I was still very wary of people, I didn't trust, I didn't want to share my inner most anything with anybody" (Gillian, 554-557).* *"Childhood, being abused, erm sexually, physically, mentally by someone who I was supposed to be able to trust. And when that happened I lost trust in everybody not just that person it was everybody (emphasis) couldn't trust anyone" (Gillian, 575-578).*
	Changing through connection & hope	*"What inspired me to go was a guy who I'd used with but I was still using and living on the estate. I was walking to the shops one day and this voice shouted me and I recognised the voice, so I turned around and didn't recognise the person who was calling me" (Gillian, 383-386).*
	Changing through connection & hope	*"I can't say I don't have the thought because I'd be lying to you if I said it never crossed my mind. I'm like, oh where did that come from but it's a healthy fear, not a freaked-out fear. But then it's an ok then maybe I need to look at something that's going on and go to a meeting" (Gillian. 1026-1030).*

Appendix J - Relational analyses

Interview 1 Relational Analysis Pseudonym - Kim

<u>World comes crashing down</u>

Realisation of inability to cope leads to help seeking (GP) 44-46

Kim lists her difficulties but her voice changes, it raises with strength for stopping prostitution but becomes vulnerable & small when she talks of asking for help. I am aware that this lifestyle & help seeking are not conducive. She repeatedly says she could not cope, & looks at me for acknowledgement of our shared understanding. The not coping was external life pressure but she also said, “with me” not coping with internal states?

Relationships as source of wounds (Relationships/others) 56-60

This is what she wanted, she wanted extra support, help, she identifies her need to heal from her relationships with men but not knowing how to go about this. Social services became involved as this seemed the only way forward to her.

Post-reflection – her identification of her needing to heal from relational trauma – recognising she needed to “get over the relationships as though she were blocked from moving forward- something was in her way but deep down knew what she needed.

Addiction leads to removal - (Social services) 88-90

There was a failure to collect children from school due substance use – she says, “**I wasn’t there”** twice in this section – but then says she lost touch with time while using.” She intended to do a good thing, going to purchase winter coats for her boys

but used the money for drink & drugs. Her loss of time resulted in a non-appearance at the school.

Consequences of addiction removal (Social services) 97-100

The children were removed following this incident, not collecting them from school, she tells of the comments made to her, that no court would give her custody. I got a sense of a woman alone, like the drawbridge had been pulled-up, shut out, closed off & locked out.

Focus of care – exclusively child based (Social services) 122-124

Her talk of social services not offering her any support evoked an abandoning rejection of her in me, it brought to mind a rebellious teenager being evicted from home, all ties being cut. Her voice changed, became quite harsh as she re-enacted their words. There seemed to be layers to this – these words echoed & resonated – **"you can go off & do whatever you want."**

No Place for you

Felt let down (Social services) 527-530

Children were returned without understanding of her circumstances, she felt let down, they said were here for the children's sake as if she didn't count and there is deflation in her voice as she talks.

Addiction not addressed by social services (Social services) 423-424

She received no support for her addiction during her first involvement with social services, she was left to deal with things herself.

Involvement needs to come from both sides (Addiction & Social services) 520-522

The actuality of her having a key-worker for herself was ***emphasised*** in her voice, this was a separation of her needs and the children's needs. she compares this to her first experience with no specific services for her and how this was a damaging way to return children with no intervention for her.

Inability to relate (Self/Relationships/Violence) 129-132

During the separation from her children -18-months – the cycle continued, the way she spoke was cyclical, another, another, another, there seemed to be relationships with violence, drink, & drugs. Her ways of relating were not grounded in people but in things and events.

<u>Change as a psychological journey</u>

When you're well you don't need to see them (Addiction service) 487-489

There is conflict in her voice with the understanding of limits to services but wellness reduces contact – this is when she picks-up her substance again.

Contrasts isolation and connection as factor in support offered

(Addiction Service) 445-448

Lack of support first time left her isolated, she identifies this as a factor in her continued use, children are gone and I'm all alone. Her voice lifts when remembering being part of a group, talking and her feelings of being non-human are removed.

Trauma and transformation

Risk of intergenerational abuse (Family) 106-107

She discloses childhood abuse from her grandfather – her concern was for her son whom had been place in his care. She speaks slowly & calmly about this not being a good arrangement & she informs social services of this history.

Violent relationship (Relationships) 36-39

She moved uncomfortably in her seat, I noticed the proviso **grown-up now**, was this a defence - my children are no longer vulnerable before telling her story? She is hesitant of disclosure – does shame still exist or is this painful? Her voice quivered when recalling a violent relationship and the situation she lived in. Alcohol, drugs and a violent pimp. When describing her managing to get out of this relationship I feel the magnitude of her experiences and struggle to escape this relationship.

Defective self-relieved through connection (AA) 674-677

She always knew something was wrong, always been knocking on doors but she walked through the doors of AA, no knocking, possible easy access to this resource? She gained connection and hope.

Interview – 2 Relational Analysis Pseudonym – Jane

<u>World comes crashing down</u>

Violent relationship 40-41

She beings by framing her involvement with social services by going further back in time to an abusive relationship with the father of her daughters. He was violent and controlling, which she says led her into drinking. He did not allow her to drink so she began hiding the drink which contributed to it getting out of hand.

Concern Raised 74-76

Social services became involved some years later, she was in a relationship and had a 6-month old son. She had drunk on and off, inferring some kind of control. Taking son to nursery, she does not remember too much other than her sister had made contact with social services.

She says the one drink, she thought the one drink, this seems to show there was more than one drink and her dropping her son off to nursery. I get the impression there must have been a telephone call resulting from this, possibly to her sister? She says she was too drunk to remember.

Son will be adopted 102-105

social services came with and police officer, there is surprise in her voice at this, as though she has been surprised at the time it had happened.

Discredited as a mother 108-111

she speaks quickly listing what was said to her by social services, her son was with family, he would be adopted-out because he was young, family did not want to keep him as they already had her two girls. She says they called her a drunk, and there was “literally” no support, “adopted-out” is repeated for a third time – this seems to be in response to her family having had enough. She repeats no support, no nothing.

I wonder about the exhaustion of family as being a means to caring for her son why adoption was the next recourse of action? Does being a “drunk” automatically result in adoption if family are not available?

No place for you

Doing everything wrong 196-200

she talks of how she would have a drink before case conferences, which she quickly follows up with how she was doing everything wrong, these words cause her voice to break as if she is holding back a need to cry.

She says she was not getting support and contrasts what she knew then and what she knows now.

Do it yourself 473-477

Her experience of support was diazepam from her GP, it was never suggested to her to go into treatment. There is help but people don’t know.

Escalation of addiction 228-231

Once her son was gone she deteriorated, she did not attend case conferences, she fell further into her drinking and began to use other substances too. She says she spent 6 months in blackout.

I identify with this as when your world is tumbling-in because you have substance problems you ironically increase your use

Change as a psychological journey

Referred to alcohol service – mixed messages 164-166

In terms of what support she was offered by social services she reflects on how she was not informed about rehabs or put in contact with self-help groups such as AA she was advised to go for CBT and speak to her GP. She attended an addiction service and was told she could reduce her drinking through the use of a drinking diary (she laughs when saying this as she seems to be aware of the futility of this action) she told them she needed complete abstinence, that reduction was not possible.

GP arranged addiction support 188-192

She had been advised to go to her GP by social worker and this is what she did. Her GP arranged her alcohol support worker – She reflects back to this experience, voice softening, and admits she used to lie to the support worker. This was quite a profound moment as the pace slows she recounts the conversation with her support worker and how her answers were automatic lies, lying to herself also, and her continued drinking.

Scared to be honest with addiction services 643-646

When feeling irritated by life she can now call on a number of people who will be there, for a coffee, chat, meeting. Talking seems to be key, talking about the things she feels others will judge as silly or stupid.

Then - Fear of service prevented her from telling the truth – having to **withhold real feelings, not able to release true feelings**, suppression – pressure – afraid this would be fed back to SSs. Conditioned to say you're ok even if you're not.

Now – multitude of people – always available – access to a resource – **letting out of pressures** – able to reach out when experiencing negative moods – talk it through and relieve the pressure.

Trauma and transformation

Mental health - Downward spiral 242-245

she states she was not supported during this period of madness, she does not know what she was doing other than there were a number of hospital admittances following attempted suicides.

She remembers coming round in a hostel – her thoughts were, I'm sober, I was in withdrawal thinking where am I, where are my children, where's my mom,

I am quite struck here by order of her thoughts on awakening, realising she was sober connected her to her withdrawal, once she had grounded those thoughts affecting her bodily experiencing her thoughts turn to others,

This seems to show how the physical need is greater in her hierarchy of needs. Basic physical needs before psychological.

The support worker in the hostel tries to help her contact her family but they had changed their telephone numbers.

Beginning to connect 302-306

once detox was over she returned to hostel, her support worker there was also in recovery from addiction. She says she is lucky because of this fact as he knew about addiction and 12-step recovery. He provided her with all the information about meetings and where to go.

It is interesting that it took her ending up in a hostel for this process to occur after being involved with services for some years now.

Drink to release pressure 521-524

she felt pressure which drove her to drink more, this was not a case of just putting the drink down. With hindsight things would have been resolved long ago if she had been directed toward her source of recovery earlier. If social services had provided better options for treatment.

Interview 3 Relational Analysis Pseudonym - Nicola

World comes crashing down

Alcohol as a means of escaping 43-47

She sets the scene of being a young single mom and finding this difficult. She had feelings of wanting to escape her child, her child was all she had but not having the support of the full support of the father caused feelings of being trapped. Possibly not

having the father their full time, not having someone to share the anxieties, that had preceded the birth, were creating feelings of needing to escape.

Alcohol service inform social services 82-84

She attended an alcohol service after she realised her drinking was a problem, showing a shift from anxieties and fears, she now realised that the drinking had become a problem. She felt it should be stopped. The alcohol service told her they would have to contact social services as she was a drinking parent.

Social services lack understanding 256-260

I ask her about social services and support provided to her during their involvement. She felt that social services did not understand addiction problems, that their way of helping people get sober was to threaten the removal of your children.

<u>No place for you</u>

No after care results in drinking 221-225

The connection she had felt, that alleviated her feeling lost returned when she finished the day programme. Although she had not achieved complete abstinence through this programme she had only drink a few times during that six months. She returned to drinking once it was over, feeling lost again, and disoriented from no longer attending the full-time course. She swallows hard, as though this particular memory was difficult, feeling alone seems to have been something she struggled with.

Change as a psychological journey

Services themselves were difficult 265-269

I ask her about support from social services. Although she had been comforted in way be her attendance at these groups, it relieved her sense of responsibility and connected her to others. The active use of group members was an added pressure to be endured to remove the pressure of social services. This all seems to skew the purpose of treatment from help and support too managing pressure of services.

She “had” to engage with the services that she was sent too, but the service itself was not conducive to her needs. She talks of people drinking at the service and she found this difficult. At the same time, she had to addend these groups, she felt pressure that she had to keep attending in order to get social services out of her life.

Lack of connection blocks honesty 401-404

When discussing her key worker at the service she says she did not really connect to her, she felt the worker was too busy. This affected her capacity to be honest with her and changed the relationship to a defensive one where she no longer talked about how she felt but just paid lip service, telling the worker what she wanted to hear. “I’m ok and I’ve not had a drink.” Her experiencing of the key worker as too busy to listen made her feel unwilling to be honest.

Learning to be honest about self 570-574

Honesty became a factor in her change process – she says when she was “brutally honest” in addiction services, even if she was saying she could not stop, this was “impressed upon her” that this was part of her journey. The admission of

powerlessness is a key factor in 12-step programmes in bringing about change. The honesty about feeling crap about life and that everything was a mess was something she learnt to do and this was seen as good as this was being honest.

Trauma and transformation

Experience suicide of other provides insight 481-487

Nicola talks softly and slowly as she discusses her own thoughts of suicide that come as she begins to believe change for her is not possible. She had already experienced two suicides in her family and reflects on the devastation this brought and her wish not to inflict the same on her children. There is a tussle in her between this being a selfish thing to do to and may leave her children with a sense of blame. This may hold some insights into her own thoughts around the suicides she has experienced possibly she carries self-blame? But these experiences provide her with enough experience to not want her children to feel the pain she has.

Hope maintained by example 461-464

How did she come back from the brink of hopelessness?

She questions herself saying there must have been a little bit of hope somewhere. She puts this down to seeing others who were not drinking and attending 12-step meetings, something she had done herself for many years.

No progression in life – (Others/AA) 469-473

Seeing the benefits of change in the lives of others showed her lack of progression. Seeing herself in relation to others of similarity polarised her standing still and not

moving toward the things she motivated for. A better job, improved mental health and the desire for a relationship – she is becoming orientated toward the future and this was something that she identifies as part of her changing process – other play a big part in her journey.

Interview:4 Relational Analysis Pseudonym - Kayla

<u>World comes crashing down</u>

Postnatal Depression 55-57

I notice her jaw is tight when talking holding tension, it takes time to warm into the interview. She talks quickly, reeling off the events but I sense from the brief dialogue so far someone who has had a difficult time from their very beginnings. She is labelled as having postnatal depression, I wonder if she had been depressed much longer than post-nataly? She quickly defends herself as a mother as the observations of her drew no concerns regarding parenting.

Not able to parent – you need to take her 68-73

Her using began to impact her young daughter who was becoming aware of her mother's need for alcohol, fetching it from the fridge without prompting. This was the last straw for Kayla, her daughter deserved better. She called social services and asked them to take her daughter. She seemed to be talking from experience as if she had lived these experiences herself, her daughter deserved better than she had had?

Use to supress pain – Chance not given 85-88

Unable to contain the emotion of the situation she absconds, runs away, having lost everything she disappears into her addiction at an accelerated rate.

<u>No place for you</u>

Not included in the process 488-490

During the adoption process of her second child, son, I ask about social services and how they were involved, meetings and proceedings. She says she was not invited to

the meetings, “bam, job done” again the women experience social services as doing a job. I know from experience that support at these times is vital as you are crumbling mentally and no about in need of psychiatric support when a child is being removed. This is not a short process, it spans many months and I understand her ultimate action of running away.

Generational addiction 458-459

I ask about who was supporting her throughout the process of having her son adopted forcibly, she only had her birth mother. Her mother was not very supportive as she has drug and alcohol addictions. Her running away for three years and immersing herself into addiction makes more sense now but she had returned and faced things.

Drink as a means to cope 482-483

I ask her about support she received while going through the process of her son being adopted. She had no support as her birth mother is also an addict, she was alone. This had the impact of sending her “doolally” she could not cope and she sunk further into addiction. She disappeared for three years.

<u>Change as a psychological process</u>

Controlled drinking 761-763

Being told she could control her drinking was unhelpful. She uses the language of AA here “your powerless over your drinking” this is why she needed help because she could not control her drinking. She continues by saying being an addict or alcoholic makes you abnormal from those who can control their drinking or drug use.

Resiliency to deal with the past 835-837

She finds someone she can be open and honest with someone who knows her completely. She talks clearly about the things she had dealt with in recovery that she formerly would drink on. These are things that she did not have the capacity to manage, past hurts that she had reservations about manging

Trauma and transformation

Sexual abuse 940-945 (I) Is this sexual abuse? (955) 957 & 961

She had been abused sexually, physically and emotionally throughout her childhood. This had occurred in the family home and the perpetrator was her older brother. This only stopped when she hit out and this had become her learnt defence when feeling threatened. These were the unprocessed issues she was unable to deal with earlier on in treatment where her anger had been used against her in the original care proceedings. Not being protected and feeling she was unable to protect her daughter triggered the initial contact with social services at the beginning of her journey

Role models 831-834

I ask her how she got from all the darkness to the light, kindness had been instilled in her as an eight-year-old child by her grandmother, always be kind. This had worked against her as she tried to continue to practice this way of being as she was in many situations where kindness was seen as weakness and made her vulnerable. When she arrived into AA, she was people who became role models for her, she wanted to be like them, talk like them, and find a person she could be thoroughly honest with. Trust had been an issue for her so it seems she found a place and people she could

begin to trust and let go of her defences that had rightfully been adopted in childhood.

Changed self-concept 841-845

Being thoroughly honest with her sponsor in AA has helped to find her true self, to remove her layers of defence, the though protective layer she had needed to find her true self and self-compassion. The kindness she sought and begin to find it treatment services was not being applied to herself, by herself. She quickly corrects herself when she swears, I say you can swear as much as you like, again I see her calmness as this was her first and only swear word throughout the interview. We laugh and it feels good, I feel comfortable with her, as we ride the wave of emotions that have carried

Interview - 5 Relational Analysis Pseudonym - Jackie

<u>World comes crashing down</u>

Insane behaviour as drink progresses 119-122

Jackie talks very fast, there is an urgency to get her words out becoming short of breath at times. My head spins a little trying to process all of her words and realising she is still not answering my original question, I feel myself becoming a little frustrated.

Jackie talks of her drinking during pregnancy with her last child and sarcastically says she didn't see this as being a problem at the time, although this was something she would never have done with her other children. She sees this as a marker of what she calls "insanity stepping in" Her change in behaviour during this pregnancy Is

contrasted to her previous three pregnancies and is something she marks as a changing point in her drinking.

This is made apparent to her in relation to her drinking becoming progressively worse behaving in ways she would not have previously.

Mother's aggression leads to social services 296-299

Jackie describes what she calls "that fateful morning" when her children were eventually taken from her care. It involved two of her children and another situation where objects were thrown. She states her son threw something at her and she retaliated and threw it back. There seems to be an automatic, instinctual, way of relating through aggressive acts. The theme of violence permeates throughout Jackie's life, from childhood, to personal relationships, then eventually to her children. There is intergenerational familial violence which the children now model. Jackie's daughter calls her estranged father to report the incident and he calls social services. Jackie changes her tone to posher voice and uses the word "Daddy" as though he were better than her or the better parent at this point.

Children taken into care 300-303

Jackie speaks softer and more slowly as she recounts being told her children were being taken into care, the fight in her voice subsides.

This is the event that "brought it to a head" the reoccurring nature of these events of aggression?

No place for you

You're just a number to social services 574-576

Jackie experiences social services as though she were just a number to them. Jackie experiences unfulfilled promises of professionals as a marker of being a number and not being held in mind enough to complete their checks. This was felt particularly when she left the mother and baby unit to return home.

Feeling unimportant/insignificant in the eyes of social services forgotten and abandoned creates support seeking via chaos.

Demonstrates not coping through drink and chaos 493-496

Following the theft from the shop Jackie is arrested and kept in a police cell overnight, she wakes at 10 pm and finds it hard to describe how she felt other than there was some form of scream from her. Her actions had been a scream for help. She is unsure if there was some relief to her actions as these now held further consequences but she is aware that her way of eliciting help at that time was dysfunctional. Jackie alludes to chaos many times throughout the interview from herself and from social services. This is something she is aware of, her own chaos but there is more chaos in her life than alcohol. Jackie's drinking makes manifest her chaos and I wonder where this went during her times of jumping through hoops and conforming? Were these never fully addressed?

Relates needs through chaos and alcohol – unable to get needs met through support systems.

Change as a psychological journey

Mixed messages 364-368

Jackie talks of her confusion of mixed messages she received from social services and addiction services. One was saying she was an alcoholic and other was saying she could learn to control her drinking.

She talks of being asked by addiction services if she wanted to stop drinking but she did not. She was in a position of blaming others and was not willing to adjust this. She answered honestly the question of if she wanted to stop drinking and said NO but identifies herself then as being in the position of blame.

This blaming seems to be attribution of problems to others as opposed to addressing something that she now sees. She says she was unaware of her alcoholism and takes the words of addiction services, that she could probably learn to control it to heart. The blame lays with them in her mind at this point.

Blaming as a defence – Confusion of mixed messages.

Trauma and transformation

Violent marriage 62-66

Jackie sets the scene of social service involvement by going back to childhood, again things looked good on the surface but her father was a violent man. She talks of alcoholism manifesting secrets and lies that may stay dormant as they did in her childhood such as growing up in a violent home but her recreation of a violent home and marriage was exposed due to alcoholism being present.

Jackie states she was in a violent marriage for sixteen years with a man who was also an alcoholic. This took a toll on her over the length of the marriage. Maybe this was part of her emotional rock bottom as she lived in an abusive violent relationship.

Surviving the system – Rebellion & Recovery 26 882-889

Jackie sees herself quite uniquely, she hesitates as she contemplates her words, then refers to herself as privileged for being given the survival instinct. This is in relation not only to her recovery from alcoholism but also surviving the system.

Her belief that people are not meant to survive the system again goes back to experiencing this process as a battle which is not meant to be won. She again credits her rebelliousness, her patterns of behaving, as something that allowed her to come through.

She is aware that those same patterns that she still has today have been moulded and shaped. They have been smoothed down and are now an asset to her sobriety. She also sees these characteristics as something that was out of proportion, something that worked against her, not some much for her survival but for her usefulness in recovery. She talks of being her true self now, something that had been lost along the way.

Interview – 6 Relational Analysis Pseudonym – Cara

<u>World comes crashing down</u>

New to motherhood, isolated, drinking & anxious, seeks help 108-112

"I had my first child in (year), I was living in you know quite an isolated place, and I was drinking a lot, urm, the drink escalated and my anxiety levels were really, really high, urm I think it got worse after having a baby, I informed the health services of how I was feeling"

Feelings of anxiety and levels of drinking reach higher levels than before baby was born. She tells health services how she is feeling.

I was broken and came crashing down 264-268

"I was just (phew) very broken, it was awful, the police, every night there was some chaos, some drama, and it happened because, it got worse because I would say it was like you know when you're spinning all these plates in the air and all of a sudden they crash down, that's what happened"

She experiences herself as broken, she uses metaphor, the spinning of plates that come suddenly crashing down. As things got worse her outward behaviours became more extreme drawing attention of police. She was losing her ability to keep the plates spinning, the prelude to her descent into drink.

Drinking goes unchallenged face to face 160-164

"the thing is which I found quite strange they didn't pick me up on it when I went, when I went to get him they didn't say no you're not taking the child, you're drunk, they just let me go with the child and then phoned social services"

The experience of not being confronted at the school and being allowed to take her child away while drunk did not seem right to her. She would have expected to have been challenged here.

Left confused at no visible involvement but needing to be supervised 176-179

"What happened to being with was they phoned me and said, 'we've had blah, blah referrals about you, you just need supervised access', and that was it, nobody came to see me, I was like what does that mean?"

Initial contact from social services was a phone call from them and a week before anyone came out to visit. There was an apparent lack of urgency in connection to the referrals that had been made about her. She needed to be supervised but none saw her. She was left confused.

Process of registering children was confusing 209-214

"I don't understand, we didn't understand why they were put on the child register when they were with my partner not me cause they weren't in my care at all, erm but they were still placed on the register, and again it was unclear because they were saying 'aww yeah you can, they can come and stay with you if you're ok"

There was confusion for her and family as to the need to register the children, the messages were mixed, the children were not in her care. Yet she could see them if she were ok?

“Do you know what they meant by ok?” 220

“Well if I’m not rolling around on the floor” 222
Her understanding was that she could have contact with her children as long as she was not drunk.

No place for you

Future needs of children do not include mother 304-306

“…I asked my social worker, the kids social worker for help finding somewhere to live so when I was sober I could live with the children and she said I’m not here for you I’m here for the children…”

While in rehab she begins to think of the future, she corrects herself, not her social worker the kid’s social worker, seeming to point to the fact that she was not represented, knowing that they were for the children and not her. She reaches out to them for help with housing once she completes her treatment. She is met with a clear message that they were not there for her but for the children.

I wonder how this is separated? How not meeting the needs of the mother is beneficial to the needs of the child?

Felt like I was nothing, like this was self-inflicted 313-316

“she, she just, the way she treated me, like I was just nothing, and I’d brought this all, maybe on myself, I just felt I didn’t have any support, that only, I was under (service name) the mental health team as well and they went “oh they can deal with her” (snooty voice)

Her experience of the social worker evoked feelings in her of nothingness, that she was nothing. She has a sense that this was a self-inflicted problem brought on by her own actions. Her use of a snooty voice when relaying what was said, her being dismissed, had had an impact of that caused her to feel at fault, to blame and therefore unworthy of support.

Everything was normal after detox – no support 526-528

“I had the detox, came back and it was like everything was normal, the kids were there, there was no support, there was nothing, it was just a detox before Christmas, I remember”

After residential detox she returned home, back to her normality, children and no support.

Pressure of hiding relieved, drink is exposed 665-669

“you know the court, everything was unravelling, I’d done so well over the years, and keeping it a secret (laughs) and holding on and it all just you know was out in the open, and you know to be honest it felt like a relief, it was out in the open and I thought I don’t have to hide it, I can just drink now”

All her work, keeping her drinking secret, was unravelling. There had been a pressure, holding on, pushing down, keeping part of herself hidden. She experiences relief from the exposure, out in the open for all to see so she drinks openly.

Change as a psychological process

You can have a lapse 909-913

"in the detox centre, they do a relapse prevention but what they say in the relapse prevention which was like gold for me, was they tell you in the group, you can have a lapse, there's a difference between a lapse and a relapse, a lapse is maybe 1-2 days and then that's in your head "ding, ding" oh so I can have a lapse then, that's fine"

The language of relapse prevention group in detox is picked apart by the addicted mind, still seeking to use.

Rehab as foundation for sobriety – Medication another substance to abuse 725-728

"…rehab was the best, you know cause as a result of that I've been sober nearly four years, erm the bad was the medication it made me worse, it did make me worse cause you give an addict or alcoholic medication they abuse it, I abused it, in the end they had to, I was only allowed one a day"

Her identification of rehab as the most useful aspect of her treatment was a place that has resulted in long term sobriety for her, in contrast her experience with medications was what she found least helpful. She repeats that it made her worse, she uses the collective addict or alcoholic they will abuse it, but then she owns this

behaviour personally, “I abused it.” Prescriptions had to be administer to her weekly to prevent misuse.

Trust and full self-disclosure as a turning point 938-942

“after step-5 wow I just felt quite amazing, I was in a room with someone who I trusted, and I trusted them whole heartedly, and I did tell them everything, there was “nothing” I kept to myself and we were there for maybe 5 or 6 hours and that was just a turning point for me as well I think”

Full one on one self-disclosure in a contained trusting environment was releasing and became a turning point.

Trauma and transformation

Feeling overwhelmed, wanted things to stop not end life 509-511

“yeah, its fine yeah, urm because it wasn’t trying to kill myself it was my head was so, I just wanted everything to stop, you know it wasn’t an intention to, I didn’t really want to die, I’m glad I didn’t”

Her ability to talk about this time was framed in a separation from an attempt to take her life to a wanting everything to stop, inferring it was her head that was troubling her.

Her response to my question about access to addiction treatment and how she received support had come about through her overdose.

Learning through a shared experience 780-785

"I enjoyed learning about myself even though a lot of it was horrible but the peers were there with you, you know that was positive the people going through the same thing and the people, the counsellors had been through the same thing, so you couldn't like, I was arrogant and cocky, I couldn't say "you don't know what I'm going through" (arrogant voice) cause they had"

A journey of self-discovery, steered through the difficult parts by those who had made the same journey. The sameness shared with others removed the barriers of separation.

Interview – 7 Relational Analysis Pseudonym Gillian

World comes crashing down

Loss of someone to talk to 179-182

Gillian missed her father, he had provided her with unconditional love and support. Although her father was not truly able to help her he did provide her with a listening ear, a place to unburden herself.

There was a void left by her father – a source of security and unconditional love that was now missing. This had provided Gillian with some form of security but now was gone. She lacked other coping mechanisms and support systems. She valued being heard even if the answers were not provided

Violent incident results in police and social service involvement 82-84

Gillian describes an incident where drug induced violence involving a knife occurs in the home as a customer is unable to purchase drugs and becomes aggressive.

Gillian is aware that during this incident her concerns are about being caught by police in possession of substances. She is aware that her focus is on the drugs and her own self-preservation which overrides her concern for the injured person.

Lacks concern for others – driven by fear of self-preservation and protection of her life world

Devastation and disbelief – resilience of children 122-125

The effects of this reality only added to an already unstable Gillian. Now her already fragile state was compounded further – disorientation and devastation.

Gillian was shocked at this reality; the impact of this news was comprehendible to her as her life was to change to such an extent she could not believe what was happening.

Her daughter's response was one of offering comfort to the mother, there seems to a role reversal where her daughter needs to reassure the mother. As grandfather had been the main influence in her children's lives his death seems to have made way for the inevitable falling apart of this family.

Daughter reassures mother – Daughter creates fantasy in her mind to protect self

Gillian is forced into a reality that she cannot comprehend – her protections are gone and the reality of her lack of ability to manage

Depression follows removal – effort only for contact 280-283

Expectations on Gillian from social services were to cut down her use and improve the home. Gillian struggled to achieve these things as once the children were gone she sunk deeper into her depression.

Gillian's world was a mess, mentally and physically. The basic expectations of cleaning herself and her home up were beyond her capability. Her motivation was gone and she was not functioning normally. Her deepening depression meant she deteriorated in terms of keeping home and needing to block out her world further with substances.

In her depression and despair, she mustards effort in relation to having contact with her children. This was the only time effort was activated in her, she was motivated to maintain contact with her children but this was an almighty effort. Outside of this she appears to have been lacking purpose and meaning.

Depression and addiction fill the void of emptiness- living in diabolical conditions she was unable to care for her surroundings. Effort only achievable though the connection to her children

No place for you

Lack of support from social services 254-257

Gillian experiences social services as something that took but did not give at that particular time. There is a cold clinical feel to the process, very matter of fact from the services in that Gillian had no back-up or support as a person herself.

Gillian experiences nothing once the children are gone other than the information that a court date will be set.

Gillian experiences some void that is left by social services once the children are gone – no back-up. Some rupture/gap – something is gone, taken, what did she need? What would constitute back-up?

Removal brings deeper decline into nothingness 242-244

Once the children were gone Gillian sunk deeper into her addiction – some anchoring had been there with the children but once they were going Gillian spiralled further into a nothingness.

Inability to be consistent deepens addiction 462-465

Gillian's addiction deepens when her children are gone – she recognises her failings as a mother to her children but there had been some form of consistency and routine that her relationship with them had required even if to a minimal degree.

The absence of the children had taken the flimsy structure that Gillian had had and this led to further decline in the addiction

Lack of children = lack of any structure = inability to self-structure

Balancing distrust and openness to dispel shame 719-722

I ask Gillian if there is anything about her that helped her though her difficulties

Gillian identifies openness as something that has been beneficial to her but this balanced with an ongoing weariness of people that she sees as a natural consequence of her abuse.

Shame had kept her closed off but letting this go has allowed her to be more open to others but a fundamental weariness remains

Trauma and transformation

Weariness and lack of trust 554-557

Gillian talks of her time in residential treatment and how she did the bare minimum for the nine months that she was there. Her time there was extended in blocks of three months as she was seen as someone who was not complying with treatment.

Gillian maintained the minimum level of engagement to remain in treatment but this was as far as she could go at this time.

Her strategy of minimum compliance to the groups kept her in treatment as she said to “hang on in there” but she had her defences up that kept her from going deeper and further into treatment.

Guarded against others – defensive and self-protecting. Lack of trust keeps others at a distance. Wary of others – unsafe/vulnerable?

Need to keep locked away her inner most self

I ask Gillian where her distrust came from- Line: 569

Learnt not to trust through betrayal 575-578

Childhood abuse – physical, sexual and mental abuse by those you are supposed to trust broke this capacity in her and meant she was unable to trust anyone.

Gillian emphasises “everybody” this fundamental betrayal meant she lost all capacity to trust anyone and this continued into adulthood.

No capacity to trust anyone = her being in the world was guarded and untrusting – leaving her in a place where she could not engage with others – she was locked in, blocked off and in a fearful place where none can be trusted

Ultimate betrayal of abuse left her in a world of mistrust = all were blocked out – there is a sadness in her voice as she tells of the point that she lost trust in all people.

Inspired by change in others 383-386

I ask Gillian if the drug worker had advised her to go into treatment her response was about being inspired by change in others:

Gillian's inspiration came from a chance encounter with a former using acquaintance. Only his voice was recognisable to her as his appearance was unrecognisable to her. He shares his knowledge of the treatment centre he had attended and she was inspired by the change in him from is former using self to enter treatment herself.

Gillian was inspired by the profound change she saw in a fellow addict to enter treatment – she had found this person unrecognisable compared to his former self

Thought of use reframed 1026-1030

The desire to use has left Gillian – but the thoughts can return – these can pop into her head at any given moment – today she sees these thoughts as non-threatening because she does not have a desire to use but she does see these thoughts as a sign that she needs some self-analysis – she attends meetings of AA.

Using thoughts are not threatening – more a sign of needing to do some self-work – what's going on? and go to a meeting. Healthy fear as opposed to unhealthy fear.

Coping strategies – thoughts as sign to check where she is at – review life – go to meeting

Appendix K - Annotated transcript example

Do you understand ME

not supported as a family unit.	156	a family do you know what I mean — something was missing from support →	Not underpinned in family support
	157		
	158	I: uhm, uhm,	
→ fragmented support	159		
	160	P: erm they were there to remove my children and do a job! →	Doing a Job! Just take children.
Focus of SS on removal	161	Not there to support a family – Job of removal. Whoes role is supportive?	
	162	I: right Job – callus emotionless	fix family – whole contained unit.
	163	wanted help to	
	164	P: and do it properly, you know they weren't there to fix things to help me fix →	Support needed to Fix
Internal workings of family broken	165	things, within the family Somethings Not there to help fix	Things in Family
	166	Me help Me broken. only to Remove	
→ wanted help but it did not materialise.	167	I: so if I were to ask you…about any erm addiction treatment services that you had	
	168	contact with	
	169	Laughs – futility of search – Knocking on doors	
	170	P: aww gosh I'd been trying addiction services [laugh] from erm from an early age	Always been Searching for help –
continuous search for help.	171	I'd been knocking doors ↓	
	172	Laughs at a seemingly long Not helpful?	
	173	I: right, ok search for help spanning many years.	
	174		
	175	P: erm it was on [location] and it was all volunteers	Volunteer service Addiction
	176		
	177	I: how did you find out about these services	
	178		
Indirect referal word of mouth.	179	P: erm I can't it was such a long time ago obviously it would have been word of →	Not direct referal Haphazard
	180	mouth or I'd seen or heard something about the service	
	181	Uncertain about learning about services – grapevine	
	182	I: ok Hearing of services via word of mouth – Not formal referal – ad-hoc.	
	183		
Needed more support.	184	P: so I did try going there but the only thing they could offer me was like a one to	Needed More? Didn't seem enough?
	185	one session with an ex-addict Someone in recovery?	
	186		
	187	I: right ok	

Polarisation.

Good + Bad

↓ ↓

Searching Substance

Missed opportunity - thoughts of recovery were not priority.

Realise then - How can this help

Realise Now - this helps.

Priorities out of sync. Lack of self care?	188		Lacked Knowledge then?
	189	P: which I didn't realise at the time might of helped me you know I went back to	Abstinence was not a priority
	190	two or three appointments and I stopped going because it just wasn't up there on	
	191	the agenda really [smiles] → Focus was still to use	
	192		
	193	I: right ok, is...that a negative or...	
	194	Always sought help - Addiction	
Self awaress of problem. Drive for help Psychological - thinks there's a problem. Lack of efficacy More efficient (Structured).	195	P: I thinks its good that you know from early on in my addictions I was trying to get	Always had awareness of substance use being bad
	196	some kind of help with it so I knew there was a problem, I always knew there was	inner awareness of problem drives help seeking
	197	a problem with my drinking and my drug use you know I didn't do it and think arr	
	198	this is really, really good do you know what I mean, it was always this isn't right,	Voluntary service becomes more efficient
	199	there's something not right here, erm, and yeah eventually erm [service name] erm	Structured? NHS?
	200	that voluntary from [first service] became like a service to a lot of people and it	
	201	moved to [service name] and its run by the trust [NHS] well I'm not sure but its run	
	202	efficiently now Always felt her use was abnormal. Never used denial Really repetition.	
	203		
	204	I: right so you see improvements	
	205		
	206	P: yeah I mean this was just the first place in [home-city] to offer any addiction, it	Out there in community Drop-in
	207	was just two junk...ex-junkies you know running like a drop in centre you know so	Good - I seeks these things.
	208	it's good that these things are out there you know and its good that I've always	Good I knew something's wrong
Motivation good Not met with efficiency.	209	tried to access something in my life Corrects Self	
	210	Seeking help - good attribute.	
	211	I: but this accessing came from you it... ↳ But not met with enough support?	
	212		
	213	P; erm, yeah that came from me erm the second time round erm social services,	Self initiated
	214	well its all scatty cause they've been in and out my life	Sequencing - Confusion events
	215	confusing - many episodes of involvement.	
	216	I: yeah	
Addiction constant SS - Intermittent. Risk.	217		Constant use
	218	P: for a long time erm cause I've constantly always been drinking if I haven't been	
	219	using drugs there was always the drink and there was times where I left the kids in	

Constant use

Long involvement with services on + off.

Long term use invoked risk to children.

Constant use made parenting precarious.

	220	the pub — Alcohol	Dysfunctional Parenting.
	221		
	222	I: uhm,	
	223		SS - Played games with children —
Risk reengages SS.	224	P: and social services were informed and they came round and they played	
	225	frustration with the kids and	
	226		
	227	I: the board game?	
	228	Not happy = not a family?	Swoopin — Play games — Be happy.
	229	P: yeah, they brought the board game round and said like we need to play games	
Preoccupation with addiction	230	and be happy more like a family and that's not really what I was thinking ov cause	Mind elsewhere — Substances preoccupied
	231	my thoughts were you know, drink and drugs mind not in same place	
	232	Ψ distracted by substances as SS	
	233	I: ok, so they were trying to help structure some happy family time, that wasn't	
	234	what you needed, it was…	
	235	mentally distracted - blocks natural Tormented parenting ability.	Battle - Demons First
	236	P: well erm that falls into place I think when you conquer your demons I think that	Family structure blocked
mental torment overrides natural instinces.	237	falls into place when you're not drinking and you're not using and you can focus,	Focus blocked substances
	238	you know you can't do the two, the two don't go together, you're not going to be	↓ Mental
Mother instinct blocked.	239	happy an joyous and free and playing frustration with the children when you're	(Family / Substance) ↓
	240	hung-over or you're thinking of your next drink so it was a bit of you know…	Can't do both Don't Mix ↓ Demon.
	241	wrong approach? Not happy, joyous, Free	
	242	I: cart before the horse Mental / Physical / bandage?	
	243		
	244	P: yeah, just and then erm I had my daughter in 2003	
	245		
	246	I: yeah	
	247		
expectations of others	248	P: and obviously family and everybody thought Ooo she's got a daughter now, this	Significance of daughter?
People misunderstood	249	is the one that'll calm her down you know and my drinking and my drug use just	
	250	went off the scale and social services were informed again	
	251		

forgetting children.

importace of daughter

People lacked understanding of her -: opposite effect

SS - Again!

Temporary substance reduction during pregnancy ends after the birth.

Pregnancy seen as solution / Girl / People misunderstand. triggers massive use